CLARK COUNTY REGIONAL OPIOID TASK FORCE

Assembly Bill 132

82nd Session of the Nevada Legislature

November 2024

Table of Contents

Section 1: Introduction

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The task force shall include a representative from a social service agency, a representative from the Department of Family Services, a representative from the Department of Juvenile Justice Services, a representative from the Southern Nevada Health District, a member with experience in the field of public health epidemiology from a list of nominees submitted by the Southern Nevada Health District, a member with experience in the field of primary health care, a member with experience in the field of mental health, a representative from the Clark County School District, a member who represents law enforcement from the Las Vegas Metropolitan Police Department, one member with experience in the field of behavioral health, one member with experience in the field of addiction medicine, one member who represents a provider of emergency medical services, one member that represents public health educators or community health workers who represent or serve persons with limited-English proficiency, one member that represents a substance prevention coalition and the Clark County Coroner or their designee.

The Task Force reviewed data relating opioid overdose fatalities and near fatalities in Clark County. This information was utilized to identify gaps in community services relating to opioids and opioid overdose fatalities using existing state and community databases and, in particular, information relating to harm reduction and substance use. Task Force members identified trends in the social determinants of health relating to opioid overdose fatalities and identified opportunities for prevention to promote recovery and to encourage collaboration leveraging existing resources to prevent substance misuse.

Section 2: Background

Clark County, the nation's 11th most populous county, it is home to more than 2.3 million citizens and has more than 45 million visitors each year. Covering both urban and rural communities, there are also five (5) incorporated cities - Boulder City, Henderson, Las Vegas, Mesquite, and North Las Vegas - within its boundaries.

Jurisdiction	**Population 2023**[1]
Clark County (Unincorporated)	1,036,864
Boulder City	15,023
Henderson	343,486
Las Vegas	669,679
Mesquite	22,810
North Las Vegas	283,724
Total	**2,371,586**

[1] Clark County, NV 2023 Population Estimates – Clark County Department of Comprehensive Planning

Section 3: Presentations Received by Task Force

The Clark County Regional Opioid Task Force held a total of six (6) in person public meetings and four (4) virtual public meetings conducted via Zoom, from January 2024 through November 2024, that included multiple presentations and educational sessions from community partners and providers.

Nevada Department of Health and Human Services' Office of Analytics

A presentation was provided on available state databases and resource tracking substance use. This presentation included an overview of dashboards, reports, and gaps.

Attorney General's Substance Use Response Working Group

A presentation was provided to provide an overview of the Statewide Substance Use Response Working Group (SURG). It further presented information on other agencies working on opioid related challenges, reporting structures, and guidelines and toolkits.

Southern Nevada Opioid Advisory Council (SNOAC)

A presentation was provided on the Southern Nevada Opioid Advisory Council (SNOAC). It provided an overview of the structure of this team, meeting requirements, and its leadership and members. This presentation also described the four-pillar approach utilized to address the substance use crisis. These pillars are prevention, rescue, treatment, and recovery.

Clark County Office of the Coroner/Medical Examiner

A presentation was provided to describe the office of the coroner/medical examiner, their function, turnaround time, limitations and current trends. It further described the death certification process and how drug related deaths are determined.

Southern Nevada Health District

A presentation was provided that described opioid overdose indicators in Clark County, NV. It covered the data sources that are utilized to produce information, statistics, and to identify trends. It further described the social vulnerability index and how these factors impact overdose risk.

City of Henderson on Fentanyl Awareness Campaign

A presentation was provided to describe the outreach campaign being utilized in Henderson, NV to target the opioid crisis. It described the priorities of prevention, treatment, peer support, and crisis intervention, harm reduction and the use of training and supplies.

Individual/families Seeking or Have Utilized Community Service Related to Opioids

A summary was provided by an individual that has a history of substance use disorder. This person described their experience with addiction to opioids and their journey to recovery.

Nevada Opioid Treatment Association (NOTA)

A presentation was provided to describe the Nevada Opioid Treatment Association. This presentation covered their mission, providers, and the goals of their program. It described their treatment platform and provided information on some of the gaps they have encountered.

Crossroads of Southern Nevada

A presentation was provided to describe Crossroads of Southern Nevada and the services they provide. These services include inpatient treatment, outpatient treatment, and follow-up care. They further described their goals of harm reduction, medication assisted treatment, fentanyl testing, and programs including peer support.

Bridge Counseling

A presentation was provided to describe Bridge Counseling and their services. They described their approaches to inpatient treatment, outpatient treatment, community outreach and crisis intervention. They provided an overview of their services and approaches to treatment. They further described plans for the future.

Clark County Fire Department

A presentation was provided to describe what the current experience is for first responders during the opioid epidemic. This presentation covered current trends related to treatment and call volume.

Las Vegas Metropolitan Police Department Overdose Response Team (ORT)

A presentation was provided regarding the Overdose Response Team and the trends they have been observing. This presentation covered their organizational structure, achievements and collaborations as well as what they are currently observing during scene responses.

The Southern Nevada Post Overdose Response Team (SPORT)

A presentation was provided to describe the Southern Nevada Post Overdose Response Team and how they collaborate with community partners to provide follow-up to survivors of overdose and others impacted by overdose. They further discussed the Social Vulnerability Index and how they have incorporated this into their practice.

Impact Exchange

A presentation was provided by Impact Exchange, a non-profit organization that aims to provide resources for harm reduction and harm minimization. This program provides community resources to decrease negative consequences related to drug use and sexual activities. It described their structure, facilities, and services provided.

PACT Coalition

A presentation was provided by this group to give an overview of the PACT Coalition and their mission to reduce substance misuse. This presentation described their approaches to prevention and projects they have dedicated to this mission.

Overdose Fatality Review

A review was provided by the Coroner and Southern Nevada Health District on current trends and an in-depth analysis was completed for deaths that meet the conditions of the trends identified. This analysis provided key insight on social determinants of health and gaps in the current system.

Presentation from Staff on Recommendations from Prior Presentations

A presentation was given by staff summarizing all the presentations received by the task force and provided a list of recommendations that have been provided by task force members, presenters, and staff.

Section 4: Existing Statewide and Community Databases

The review process included a review of state databases, local health district data, presentations received, the prescription monitoring program database, and internal data provided by the Clark County Coroner's Office. Additionally, an all-area medical record search was completed for the cases requiring an in-depth review.

- **Current Applications:** The Southern Nevada Health District (SNHD) employs a range of applications to monitor overdose morbidity and mortality, enabling both immediate and near-term insights into substance use morbidity and mortality. These tools are categorized based on their data timeliness, with some offering real-time updates and others providing retrospective data that become available after being reported.

  Real-time Systems

  - **Overdose Detection Mapping Application (ODMAP):** Developed by High Intensity Drug Trafficking Areas (HIDTA), ODMAP is a national tool tracking both fatal and nonfatal overdoses through a live API linked with Nevada's State Emergency Medical Services (EMS) database, providing up-to-date overdose data for Clark County.
  - **ESO:** This platform captures EMS data in real-time and links it with hospital outcome data, allowing for on-demand reports and dashboards. SNHD has leveraged ESO since 2021 to track non-fatal opioid overdoses.
  - **Electronic Surveillance System for the Early Notification of Community Based Epidemics (ESSENCE):** A surveillance system monitoring emergency department visits across Clark County with customizable queries to detect and analyze overdose-related cases in real time.

  Near-term Systems

  - **Electronic Death Registry System (EDRS):** Managed by SNHD's Office of Vital Records, EDRS records confirmed drug-related deaths using ICD-10 codes, with a data finalization period of approximately three months.

- **Center for Health Information Analysis (CHIA):** Operated through UNLV's School of Public Health under contract with Nevada DHHS, CHIA gathers specific hospital billing data from inpatient, outpatient, and ambulatory surgical centers.
- **Nevada EMPOWER Program:** A wastewater-based surveillance system monitoring opioid, benzodiazepine, stimulant, and emerging substance levels to assess community substance use trends over time.
- **Naloxone Distributions & Administrations:** SNHD's naloxone program tracks the number of naloxone doses distributed and administered across the community, following comprehensive training for first responders and key stakeholders in opioid overdose response.

Together, these applications offer a combination of immediate data for rapid response and aggregate data for broader trend analysis, balancing speed with comprehensive, confirmed insights to inform timely interventions.

- **Substance Use Dashboards:** Substance use dashboards provide a centralized view of substance use data, trends, and demographic breakdowns to support public health monitoring and response. Both the DHHS Office of Analytics and the Southern Nevada Health District (SNHD) offer substance use dashboards that serve different but complementary roles in tracking and addressing substance use in Nevada.
    - **SNHD's Substance Use Dashboard:** The SNHD Substance Use Dashboard updates monthly and offers accessible data on overdose deaths and hospitalizations as well as drug checking data within Clark County. Additionally, it provides resources for harm reduction, such as information on obtaining naloxone and fentanyl/xylazine test strips, helping the community to be informed about substance use issues.
    - **DHHS Office of Analytics Dashboard:** The DHHS Office of Analytics Substance Use Dashboard offers a state-wide and county-level overview on substance use, including demographic details by age, sex, and race/ethnicity. This dashboard tracks overall trends and provides a comprehensive breakdown of substance use patterns across Nevada, enabling better-targeted public health interventions.

Together, these dashboards support a coordinated approach by providing both local and state-level insights into substance use and overdose trends.

Section 5: Current Trends and Issues Identified

The following zip codes were identified in data provided by both the Office of the Coroner and the Southern Nevada Health District as having the highest crude opioid overdose death rate.

Zip Codes of Highest Crude Opioid Overdose Death Rates

Top Resident ZIP Codes with the Highest Crude Opioid Overdose Death Rate per 100,000 Clark County Residents, 10/2023-08/2024			
ZIP	Count of Deaths	Population	Rate per 100,000
89101	32	41479	77.147
89104	21	36516	57.509
89106	12	30811	38.947
89119	15	47594	31.517
89121	19	67609	28.103
89103	12	45170	26.566
89011	11	41693	26.383
89123	13	58026	22.404
89115	13	73305	17.734

- Drug trends have been shifting the route of administration from injection to inhalation. This is often done in combination with smoking methamphetamine.
- New emerging novel substances have been identified in deaths involving Clark County residents. Deaths from carfentanil have risen from 0 in Clark County residents in the past 5 years to 15 in 2024. Deaths involving xylazine have risen from 1 death in 2020 to 12 in 2024.
- Historically, fentanyl was primarily found in adulterated drugs and users were unaware of its presence. Now individuals are seeking fentanyl as their drug of choice as they have adapted to the illicit drug supply.

Naloxone Distribution Between 10/2023 - 8/2024

Naloxone Distribution by SNHD, 10/2023 – 08/2024	
Year	Number of Doses Distributed
10/2023 – 08/2024 *	64,517
*2024 data are preliminary and subject to change	

Naloxone Administrations from Naloxone Distributed Through SNHD's Linkage to Action (L2A) Team, 10/2023 – 08/2024	
10/2023 – 08/2024 *	358 (349 successful reversals)
*2024 data are preliminary and subject to change	

Naloxone Administrations from Naloxone Distributed Through FR-CARA and SOR Funds Managed at SNHD, 10/2023 – 08/2024	
10/2023 – 08/2024 *	183 (177 successful reversals)
*2024 data are preliminary and subject to change	

Trends in Social Determinants of Health

- Deaths from Methamphetamine and Fentanyl have increased by 137.50% for individuals aged 30-34 and by 90.91% for individuals aged 40-44. This is based on data from October of 2023 through August of 2024.
- Deaths from Fentanyl have increased by 77.5% for individuals aged 30 to 34 and by 50% for individuals age 45-49. This is based on data from October of 2023 through August of 2024.
- Drug deaths increase significantly in high temperature months. Opioids, methamphetamine and other drugs cause a body to lose its ability to conduct thermoregulation.
- Histories of unemployment and lack of permanent housing was identified as a social determinant impacting drug fatalities.
- Unequal access to treatment based on the social determinants of health.
- Often individuals that need services the most lack permanent housing, reliable transportation, and job security.
- There is a significant stigma regarding drug use**.** There is a fear of criminal prosecution for seeking help.
- Recent incarceration and reentry.
- Comorbidities related to behavioral health.
- The use of illicit polysubstance.
- Illicit drug supply that would contain fentanyl and the user is unaware.
- Individuals who have no idea how to recognize the signs of overdosing.

Section 6: Gaps in Current System

The Committee has identified the following gaps in the systems of care serving Clark County residents, identified through presentations and data provided to the committee, fatality data review led by the Clark County Coroner and Southern Nevada Health District. Currently there are significant funding limitations to address the needs of the community. Funding is lacking in numerous areas and would need to be addressed to have a large impact.

Workforce

- Licensed mental health professionals, family services workers, and other human services professionals are facing workforce challenges including staffing shortages, retention of staff and turnover in difficult positions.
- There is a lack of peer support, mental health resources, and treatment options for the prevention of burnout, compassion fatigue and vicarious trauma for human service professionals working with this population.
- These professionals also face significant challenges related to reimbursement from insurances, often to have to implement a sliding scale for providing services, this creates challenges for these professionals to make a living wage that is comparable for their education and training.
- Current treatment centers lack capacity to expand access to opioid addiction services, addressing current capacity limitations.

Training

- Limited number of providers with specialized training for the treatment of substance use disorders with training in culturally sensitive trauma informed care.
- Limited participation in project ECHO by local medical providers.
- Stigma often prevents individuals from seeking treatment.

Lack of Service and Treatment

- Lack of funding for agencies to provide or expand the services needed to address the availability of naloxone (NARCAN) kits.
- The Nevada Division of Public and Behavioral Health set a goal for naloxone to be used in 80% of witnessed overdoses. To achieve this, approximately 115,000 two-dose naloxone kits would need to be distributed annually across Nevada.
- Since Clark County accounts for 73% of the state's population, it would require distributing 83,950 two-dose kits each year to meet this saturation goal.
- From October 2023 through August 2024, SNHD further increased distribution, providing 32,259 two-dose kits due to increased funding availability from the Center for the Application of Substance Abuse Technologies (CASAT) within the School of Public Health at the University of Nevada, Reno (UNR).

- Despite this significant progress, there was still a deficit of 51,691 kits required to reach the saturation point and meet the state's target for naloxone use in 80% of witnessed opioid overdoses.
- Individuals seeking treatment may face a delay, and current provider capacity is insufficient to meet the current demand for substance use treatment services.
- Individuals seeking substance use treatment services may experience extended wait times, due to delays and/or barriers stemming from insurance utilization and approval processes.
- Lack of access to resources, supports, and/or services in the community due to service hours or hours of operation by agencies, such as lack of availability of weekend and evening hours for service support.
- Lack of community programs targeting prevention. Including programs targeting youth that are provided with a culturally competent approach.
- There is an ongoing need for further community outreach to vulnerable populations including the unhoused.
- A lack of community prescription drug disposal programs.
- A lack of effective patient education on the addictive potential of opioids. Lack of education for patients on pain management expectations.
- A lack of patient education related to polysubstance use.
- A lack of available alternative therapies for chronic pain and chronic illnesses and a lack of insurance to support these alternatives.
- There is a lack of access to substance use treatment, particularly for youth.
- Lack of centralized guide of existing resources/agencies currently available to the general public or those seeking resources.
- Gaps in mental health support, such as providing culturally sensitive trauma informed care, and care in school settings.
- A variety of opioid treatment programs exist, but they are not sufficient to meet the growing needs or population of Clark County. Enhanced treatment options are essential to align with funding priorities and address service gaps related to the continuum of care, ensuring comprehensive care that is provided utilizing an approach that is wholistic and culturally competent for all residents.
- Existing treatment services often lack comprehensive long-term support for people within the community (i.e., a recovery-oriented system of care). There is a critical need for more long-term recovery and aftercare services such as recovery housing, peer recovery coaches, sober living homes, ongoing counseling, and employment training. These services are vital for maintaining sobriety and preventing recurrence of use, thus improving health and wellness, reducing long-term healthcare costs, and improving public safety.

- Existing facilities range from inpatient mental health hospitals to various rehabilitation centers offering detox, inpatient, and outpatient services. Many facilities are at capacity or unable to meet the high demand, particularly impacting uninsured individuals and residents in underserved areas.

Lack of Access to Resources

- Inadequate access to affordable and available housing contributes to this community need.
- The housing market is challenging, further burdening those with opioid use disorder or those in recovery. There is some recognition of the need for recovery housing, but efforts are limited. Critical need for low-barrier and affordable and supportive housing for individuals with substance use disorders, especially as part of a comprehensive public health approach. Stable housing is a fundamental need that supports recovery and reduces vulnerability to recurrence of use. Addressing housing instability directly correlates with reducing overdose risks and promoting well-being.
- Efforts to address overdose prevention and opioids are primarily concentrated in urban areas of the county, like Las Vegas. Lack of targeted collaboration and support for rural areas in Clark County. Ensuring equitable access to services across urban and rural areas is essential for comprehensive public health coverage.
- Individuals wanting treatment may experience significant delays in receiving it because of insurance, prior authorizations, and limited funding.

Lack of Data

- Medical records are not always available in a central repository which can cause significant delays in determining if an incident is drug related.
- Hospitals are inconsistent in conducting urine drug screens on patients with histories of drug use and in patients being prescribed narcotics.
- The Nevada Prescription Monitoring Program (PMP) only allows a 2-year history and there is a gap in the collaborative practice agreements and communication between prescribing providers.
- Health authorities including the Southern Nevada Health district do not have access to Nevada Prescription Monitoring Program.
- Data lag times and a lack of available data. There is significant lag time in the reporting of opiate related deaths. This is due to standard turnaround times, ancillary testing, report requests, medical records requests, and staffing shortages.
- Behavioral health trauma data at the local level is a gap.
- Law enforcement currently does not complete comprehensive drug screens on impaired drivers if they already failed a breathalyzer.
- A very small portion of seized drugs get a comprehensive analysis to identify drug content.

Section 7: Clark County Regional Opioid Task Force Recommendations

The Clark County Regional Opioid Task Force's efforts highlight the significant and collaborative cross-jurisdictional efforts and current outcome-based programming in place to reduce the impacts of opioids on our community. The following recommendations can be divided into cross cutting issues areas, all suggested to address the gaps identified by the Committee.

Regional Oversight and Review

- Recommendation for the establishment of a Comprehensive Opioid Overdose Surveillance and Prevention Committee.

- Purpose: To establish a Comprehensive Opioid Overdose Trends Review Committee ("Committee") comprising multidisciplinary experts and interagency representatives to address the critical public health concern of opioid overdoses in Clark County. This committee shall be bound by confidentiality to encourage information sharing but not compromising HIPAA compliance or privacy rights. All shared information from the committee shall be deidentified.

- Scope and Objectives: The Committee shall be charged with three primary responsibilities:
    - Systematic Review and Analysis:
        - Conduct comprehensive surveillance of all opioid-related overdose incidents within Clark County
        - Review a representative sample of fatal overdose cases
        - Maintain detailed documentation of findings and trends
    - Risk Factor Assessment - The Committee shall evaluate multiple dimensions of each case, including:
        - Individual-level risk factors
        - Social determinants of health
        - Housing stability and access
        - Criminal justice system involvement
        - Additional contributing factors as identified
    - Policy Development and Resource Allocation - The Committee shall submit annual reports to the Board of Clark County Commissioners and other community stakeholders, addressing:
        - Emerging drug trends that pose significant overdose risks
        - Identified systemic gaps in prevention and treatment
        - Evidence-based and promising practices for overdose prevention

- Specific recommendations for:
    - Educational initiatives
    - Prevention strategies
    - Treatment program enhancements
    - Resource allocation priorities

Requirements for Implementation of Systemic Review

- Provide access to providers NRS 439.589 Health Information Exchange (HIE) mandates with options to break the glass in emergency treatment situations. Recommend legislative changes to make Nevada an Opt-Out model, allowing for a significant increase in information sharing.
- Prescription Monitoring Program access for local public health authorities (SNHD).
- Advocating for policies for preventative measures to target population health.

Law Enforcement Intervention

- Target large-scale distributors: Focus tougher penalties on major suppliers and organized crime networks, rather than low-level offenders.
- Enhance surveillance and intelligence: Increase the use of technology and cross-agency intelligence sharing to identify and disrupt drug trafficking networks.
- Monitor and evaluate: Continuously assess the impact of tougher penalties on reducing drug supply and overdose rates, adjusting as needed.
- Seize the assets of drug traffickers: Implement stronger forfeiture laws to confiscate assets linked to drug trafficking and use those funds for overdose prevention and treatment programs.

Opportunities for Collaboration

- Utilize existing prevention coalitions to engage diverse communities and stakeholders in the development of policies, processes, program planning and implementation.
- Evaluation, such as community based participatory research.
- Increase participation in planning overdose prevention education amongst people who use drugs (PWUD) and people who are at risk of overdose.
- Provide support to Clark County Law Enforcement Organizations for collaboration with international partners:
    - Work with international law enforcement agencies to dismantle global drug trafficking operations.
    - Combine efforts in identifying countries that are funneling the necessary precursors to Mexico where illicit fentanyl is being manufactured and distributed to the United States.

- Work with schools and community organizations to provide parents with information on how to talk with their youth about the dangers of substance use, how to get them the help they need and to increase awareness among coaches who work with youth on the potential dangers of prescription pain medication.
- Collaborate with the Southern Nevada Health District to review data on overdoses, both fatal and non-fatal, and naloxone administrations.
- Provide hospitals with more resource information or establish protocols where staff will put a patient surviving an overdose, in contact with a liaison from behavioral health or substance use treatment programs. In the case of minor patients, ensure these practices are extended to their families or care providers.
- Expanding harm reduction programs like increasing the issuance of naloxone at the detention centers and areas highly impacted by overdoses.

Community Education Needs

The Committee recommends development of a centralized guide of services to be updated regularly and targeted community education campaigns in the following areas:

- Provide community education on risks of opioids, naloxone use and harm reduction. This should include targeted education to youth and families on substance use disorders, awareness of the opioid epidemic, naloxone use, and overcoming the stigma related to discussing these topics with health care providers.
- Educate parents on recognizing key signs that may indicate if their child is using substances.
- Provide parents and community members with information on the impact of trauma, adverse childhood experiences and the importance of trauma-informed care in understanding and addressing these behaviors.
- Parents should be provided resources to connect them to community-based resources and provided support if their child is struggling with substance use.
- Educate faith-based organizations who often drive into areas with a high homeless population and provide food and clothing. These groups can look for individual signs of behavioral health and addiction and offer information on resources and harm reduction supplies such as naloxone.
- Review available community-based programs to determine best practices for education and prevention that are founded in evidence-based and culturally sensitive practices. Review their availability to the zip codes with the highest crude rates.
- Implement social, cultural and emotionally competent early substance use intervention programs starting in high-risk elementary schools. Tailor program to respect and understand the diverse cultural backgrounds of participants, which includes recognizing different beliefs, values and practices related to substance use and health.
- Providing education in early learning settings to educate youths on healthy coping mechanisms and mindfulness tools for improvement of overall wellness.

- Increase public education using public campaigns through multiple media channels. For example, by providing a campaign that presents factual data of drug trends and statistics on deaths resulting from drugs.
- Increase research and education on upstream approaches to prevention efforts.
- Increase community awareness surrounding trauma and provide education on trauma informed care.
- Provide community education on options for the treatment of opioid use disorders, including research and education on holistic and complementary and alternative treatment therapies for chronic pain and chronic illnesses (i.e. acupuncture, neuromuscular massage therapy, etc.).
- Education for overall wellness for strengthening family communications, problem solving, and bonding.
- Gaps in funding for community education.
- Increase culturally relevant educational outreach and preventative services such as methods for community-based participatory research (CBPR), including education on the Good Samaritan Drug Overdose Act and overdose risk.
    - Provide programs to reduce the stigma surrounding substance use disorders with cultural sensitivity. Target the public, healthcare providers, and anyone that is likely to work with this population.
    - Provide targeted interventions that address the stigma through culturally competent providers, peer supporters and community health professionals.
- Launch public awareness campaigns aligned with national best practices to decrease substance use.
- Provide judges and prosecutors with specialized training on the opioid crisis to ensure consistent training.
- Strengthen law enforcement training in the areas of the opioid crises, adverse childhood experiences, trauma informed care and behavioral health.
- Increase opportunities for alternative sentencing that are based on rehabilitation and harm reduction.
- Naloxone should be made more available to family and friends of individuals with opioid addiction.
- Develop harm reduction and treatment strategies that address the unique challenges of Black Indigenous and People of Color (BIPOC) communities, particularly with a focus on those with a history of incarceration. Outreach should be culturally sensitive, and trauma informed.
- Establish mobile wound care services or clinics to address the physical health needs of unhoused individuals. Improving physical health can mitigate the effects of substance use.

- Evaluate programs to identify evidence-based practices and implement programs in Clark County that demonstrate high success rates. Consider collaborative efforts with other professional organizations, private and public groups.
- Provide more training on opioid misuse, overdose prevention and the compassionate overdose response.

Address Provider Shortages and Increase Provider Outreach and Support

The committee found several areas in which there is a need to address gaps in staffing and provider support and outreach.

- Increase community health workers and peer support specialists to assist in efforts to provide community outreach to diverse and vulnerable populations and to reduce stigma.
- Provide evidence-based treatment protocols for those using multiple substances and for those with co-occurring behavioral health and physical health disorders.
- Enhance care coordination in emergency rooms for individuals who arrive after an overdose.
- Seek opportunities to provide continuing medical education credits through both Clark County Medical Society as well as the Nevada Osteopathic Medical Association and consider outreach to Resident programs at local hospitals and two local medical schools, as well as local primary care community.
- Provide educational incentives – such as scholarships, loan repayment programs, tuition reimbursement, and continuing education grants – to attract and retain diverse providers, including primary care physicians, addiction specialists, psychiatrists, nurse practitioners, physician assistants, licensed social workers, certified addiction counselors, first responders and certified community health workers. These incentives will address workforce shortages across prevention, treatment, and recovery services, ensuring communities have access to the specialized care needed to combat substance use disorders and related challenges.
- Increase availability for the continuum of care including long term treatment, outpatient care and available access to all age groups.
- Enhance harm reduction programs:
    - Broaden the availability of needle exchanges, safe and free naloxone distribution.
    - Offer naloxone to subjects being released from jail or other incarceration setting.
- Create a system within our detention centers to identify individuals showing signs of behavioral health and provide support and services.
- Invest in peer support programs to enhance recovery outcomes and build a sustainable, trained workforce of individuals with lived experience in substance use recovery.
- Provide funding for additional epidemiological support, forensic technicians and enhanced drug testing to detect novel substances in overdose cases. This will increase the ability to track emerging drug trends and improve overdose prevention efforts.

Data Initiatives

- To improve timeliness in reporting and ensure prompt community notifications during overdose spikes, it is recommended to enhance the integration, responsiveness and real-time capabilities of existing overdose surveillance applications. Currently, tools such as Overdose Detection Mapping Application (ODMAP), ESO, Electronic Surveillance System for the Early Notification of Community Based Epidemics (ESSENCE) and Electronic Death Registry System (EDRS) provide essential data on overdose incidents, yet opportunities exist to further streamline data-sharing and reduce reporting delays.
    - **Enhance ODMAP Functionality:** Introduce substance-specific filtering to ODMAP, allowing users to differentiate between substances involved in overdose incidents. This enhancement would improve data accuracy and utility, addressing a current limitation of the application.
    - **Reduce Data Finalization Delays for Mortality Reporting:** While EDRS captures confirmed drug-related deaths, the current 3-month data finalization period can limit its effectiveness in real-time notification efforts. Exploring ways to accelerate reporting and incorporating preliminary data as available could improve the timeliness of overdose mortality reports.
    - **Enable Predictive Analytics for Proactive Alerts:** Implementing machine learning models to analyze historical and real-time overdose data could enable predictive analytics, allowing systems to issue preemptive alerts when data suggests an impending spike. This approach can help shift efforts from reactive to proactive, allowing agencies to deploy resources more strategically.
    - **Incorporate Preliminary Data and Rapid Toxicology**: Incorporating preliminary data, such as unconfirmed overdose cases or provisional toxicology results, can provide earlier insights. This practice helps capture trends before data is finalized. Developing policies to release preliminary overdose data responsibly can enhance prompt notifications while still preserving accuracy.
- Implementing these enhancements can improve the reliability of immediate reporting, minimize the trade-offs between speed and accuracy, and support timely, coordinated responses to overdose spikes.
- To support local health authorities further, access to currently unavailable datasets is essential:
    - **Prescription Drug Monitoring Program (PDMP) Data:** Expanded access to individual-level PDMP data for local health authorities could enhance the tracking of prescription trends, aiding in the early detection of potential misuse. This insight could help inform timely public health interventions. NV Rev Stat § 453.164 (2023) currently defines uses of this system and access, an amendment may be required to incorporate this recommendation.

- Having access to PDMP data could greatly improve the ability to identify emerging patterns in prescription misuse and respond proactively with targeted interventions to prevent overdose events.
- To promote existing data platforms among law enforcement, fire departments, ambulance services, and other emergency responders. ODMAP presents a valuable tool for tracking and monitoring overdose incidents among first responders and could serve as a central resource for real-time data integration. Additionally, SNHD's Substance Use Dashboard complements ODMAP by offering monthly updated, accessible data on substance use trends, overdose deaths, and hospitalizations, as well as resources for harm reduction tools like naloxone and fentanyl/xylazine test strips. This dashboard provides a comprehensive view of overdose patterns, drug-checking insights, and locations for obtaining preventive resources, keeping responders and the public informed on substance use issues in Clark County.
- Continue to monitor geographical locations where hotspots are located and share information with community providers.

Funding

The Clark County Regional Opioid Task Force recognizes that limited options exist for expanded funding and intends to work with the County and Southern Nevada Health District proactively to try to address areas identified in the recently completed Clark County Opioid Needs Assessment submitted to the State, a copy of which is attached to this report in the Appendix.

The following additional recommendations were offered:

- **Medicaid/Medicare:** This could include an increase funding percentage for Medicaid/Medicare reimbursements for substance use disorder and consider funding to offset costs and fill gaps related to Medicaid/Medicare reimbursements.
- **Targeted Grant Opportunities:** The Committee also recommends seeking alternatives to supplement grant funding for medical interventions including medication for community distribution.

Section 8: Conclusion

The Clark County Regional Opioid Task Force efforts have highlighted existing community resources and efforts to prevent and promote recovery for persons with substance use disorder. Additionally, the Task Force has identified critical gaps and needs within our community. Through the Task Force's recommendations and the community's collective commitment, we can mitigate the impact of the opioid crisis on our region.

We would like to extend our gratitude to the Board of County Commission for their attention to this critical issue and for the opportunity to contribute to this committee. We look forward to continued collaboration as we work together to find solutions that enhance the well-being of our fellow Southern Nevadans.

Section 9: Appendix

A. Assembly Bill 132 – 82nd Session

B. Task Force Members

C. Nevada Department of Health and Human Services' Office of Analytics Presentation

D. Attorney General's Substance Use Response Working Group Presentation

E. Southern Nevada Opioid Advisory Council (SNOAC) Presentation

F. Clark County Office of the Coroner/Medical Examiner Presentation

G. Southern Nevada Health District Presentation

H. City of Henderson on Fentanyl Awareness Campaign Materials

I. Nevada Opioid Treatment Association (NOTA) Presentation

J. Crossroads of Nevada Presentation

K. Bridge Counseling Presentation

L. Clark County Fire Department Presentation

M. Las Vegas Metropolitan Police Department Overdose Response Team Presentation

N. The Southern Nevada Post Overdose Response Team (SPORT) Presentation

O. Impact Exchange Presentation

P. PACT Coalition Presentation

Q. Overdose Fatality Review

R. Staff Presentation on Recommendations from Prior Presentations

S. Meeting Minutes

T. Opioid Use/Opioid Use Disorder Community Needs Assessment for Clark County and the Southern Nevada Health District

U. Overdose Fatality Review: A Practitioner's Guide to Implementation

V. Resources for Creating a Drug Fatality Review Committee

Appendix A

Assembly Bill No. 132–Assemblymen Cohen; and ●rentlicher

CHAPTER.....

AN ACT relating to public health; requiring the Clark County Board of County Commissioners to establish a Regional Opioid Task Force to study certain issues relating to opioid overdose fatalities; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

This bill requires the Clark County Board of County Commissioners to establish a Regional Opioid Task Force to review data relating to opioid overdose fatalities and near fatalities and use such data to address gaps in community services relating to opioids and opioid overdose fatalities. This bill also requires the Clark County Board of County Commissioners to appoint the members to the Task Force who must be certain persons, represent certain organizations or agencies or have expertise in certain areas. This bill further requires the Task Force to submit a report to the Governor and Director of the Legislative Counsel Bureau with a summary of the work of the Task Force and recommendations for legislation.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. 1. The Clark County Board of County Commissioners shall establish a Regional Opioid Task Force, consisting of the following members appointed by the Clark County Board of County Commissioners:

(a) One member who represents a social services agency in Clark County;

(b) One member who represents the Department of Family Services of Clark County;

(c) One member who represents the Department of Juvenile Justice Services of Clark County;

(d) One member who represents the Southern Nevada Health District;

(e) One member with experience in the field of public health epidemiology selected from a list of nominees submitted by the Southern Nevada Health District;

(f) One member with experience in the field of primary health care;

(g) One member with experience in the field of mental health;

(h) One member who represents the Clark County School District;

(i) One member who represents law enforcement selected from a list of nominees submitted by the Las Vegas Metropolitan Police Department;

(j) One member with experience in the field of behavioral health;

(k) One member with experience in the field of addiction medicine;

(l) One member who represents a provider of emergency medical services in Clark County;

(m) One member who represents public health educators or community health workers who represent or serve persons with limited-English proficiency;

(n) One member who represents a substance use disorder prevention coalition in Clark County; and

(o) The Clark County coroner or his or her designee.

2. The Task Force shall:

(a) Review data relating to opioid overdose fatalities and near fatalities in the county to identify gaps in community services relating to opioids and opioid overdose fatalities;

(b) Identify existing statewide and community databases that contain information relating to harm reduction and substance use to assist in identifying gaps in community services and developing targeted interventions relating to opioids; and

(c) Ensure any data reviewed by the Task Force is comprised of multiple sources and databases.

3. After reviewing data pursuant to subsection 2, the Task Force may elect to conduct:

(a) A systemic review of opioid overdose fatalities occurring on or after October 1, 2023, as necessary to determine the responsiveness of community services; or

(b) A review of opioid overdose fatalities in the zip codes of Clark County with the highest numbers of opioid overdose fatalities.

4. In addition to the requirements of subsection 2, the Task Force shall identify:

(a) Any trends in the social determinants of health relating to opioid overdose fatalities; and

(b) Opportunities for collaboration to leverage existing resources to prevent opioid overdose fatalities, prevent substance misuse and promote recovery for persons with addictive disorders.

5. Beginning not later than January 1, 2024, the Task Force shall meet not less than once each quarter. The meetings of the Task Force must be conducted in accordance with the provisions of chapter 241 of NRS.

6. The Clark County Board of County Commissioners shall ensure that there is sufficient staffing to support the administrative needs of the Task Force.

7. On or before December 30, 2024, the Task Force shall submit a report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature which includes a summary of the work of the Task Force and any recommendations for legislation.

Sec. 2. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 3. This act becomes effective on October 1, 2023, and expires by limitation on December 31, 2024.

20 ~~~~ 23

Appendix B

Clark County Regional Opioid Task Force Members

Board Member	**Professional/Community Affiliation**
Melanie Rouse, Chair	Clark County Coroner
Jamie Sorenson, Vice Chair	Social Services Agency in Clark County
Meambi Newbern-Johnson	Department of Family Services of Clark County
Eboni Washington / Alexa Rodriguez	Department of Juvenile Justice Services of Clark County
Jessica Johnson	Southern Nevada Health District
Brandon Delise	Public Health Epidemiology
Jerry Cade	Field of Primary Health
BachTrinh Dang	Field of Mental Health
Rosa O'Bannon	Clark County School District
Greg Theobald	Law Enforcement (Metro)
Geoconda Hughes	Field of Behavioral Health
Thomas Alfreda	Field of Addiction Medicine
Brian O'Neal	Provider of Emergency Medical Services
Dolletta Mitchell	Public Health Educator or Community Health Worker
Chelsi Cheatom	Substance Use Disorder Prevention Coalition

Appendix C

Joe Lombardo
Governor

Richard Whitley
Director

Opioid Data Sources and Reporting

Office of Analytics

Natalie Bladis, Biostatistician III

March 14th, 2024

Department of Health and Human Services

Helping people. It's who we are and what we do.

Agenda

1. Review available state databases and resources tracking substance use.
2. Publicly available opioid data.
   a) Dashboards
   b) Report
3. Gaps and areas of further study.

Available Data Sources

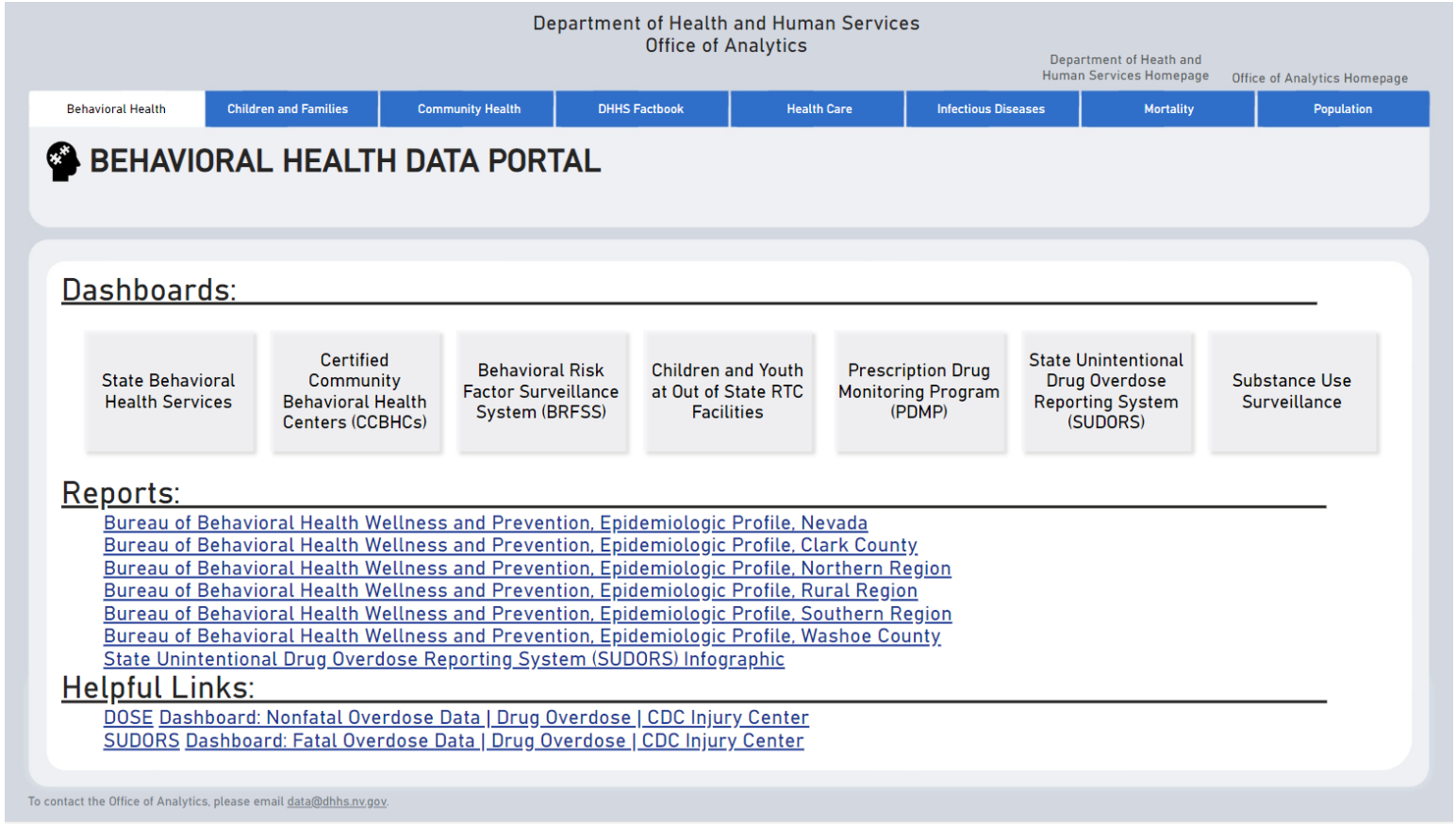
Treatment Episode Data Sets (TEDS)	Drug Overdose Surveillance and Epidemiology (DOSE)	Vital Records	Prescription Drug Monitoring Program (PDMP)
• State funded substance abuse treatment centers admission and discharge records	• Chief complaint related to substance use from EMS/ED (daily)	• Birth – mothers self report drug use (separate category for opioids) • Death - ICD-10 Codes • State Unintentional Drug Overdose Reporting System (SUDORS)	• Database of controlled substance prescriptions dispensed to patients in Nevada

Available Data Sources (continued)

Hospital Emergency Department Billing (HEDB)	Hospital Inpatient Billing (HIB)	AVATAR	Medicaid Decision Support System (DSS) and Medicaid Data Warehouse	National Violent Death Reporting System (NVDRS)
• Collected using a standard universal billing form for patients who used an emergency room service.	• Health billing data for patients discharged from Nevada's non-federal hospitals.	• Adult mental health data from state funded mental health facilities. • Shows co-occurring substance use disorders.	• Claims show Medicaid recipients who are receiving treatment for substance use.	• Violent deaths related to opioids show up as poisoning from drug use.

Public Dashboards and Reports

- Office of Analytics homepage
- The dashboards and reports are located on the OOA Data portal:

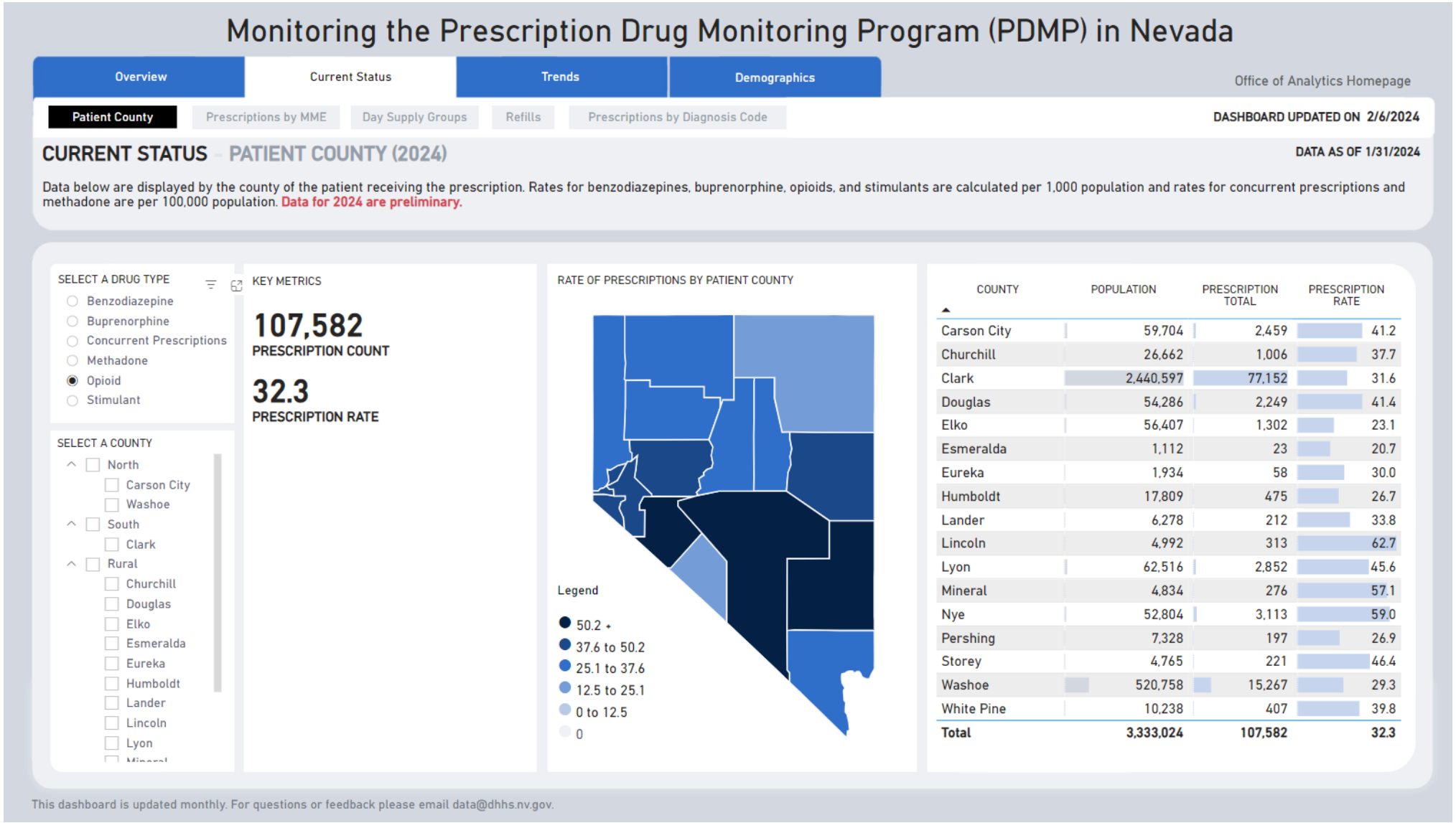


DHHS Data Portal Dashboard

Substance Use Surveillance Dashboard

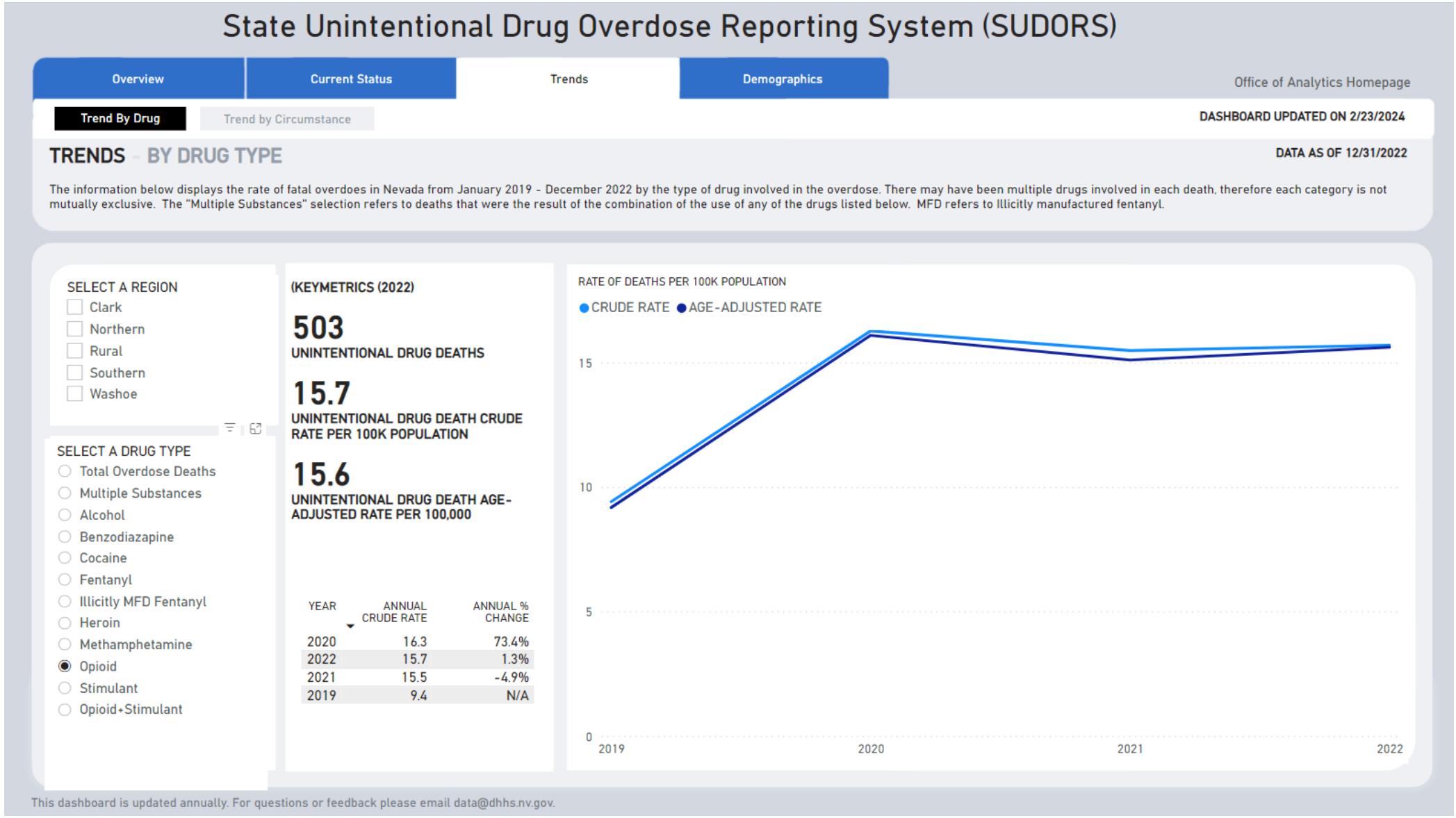
Substance Use Surveillance Dashboard

Prescription Drug Monitoring Program (PDMP) Dashboard



[PDMP Dashboard]

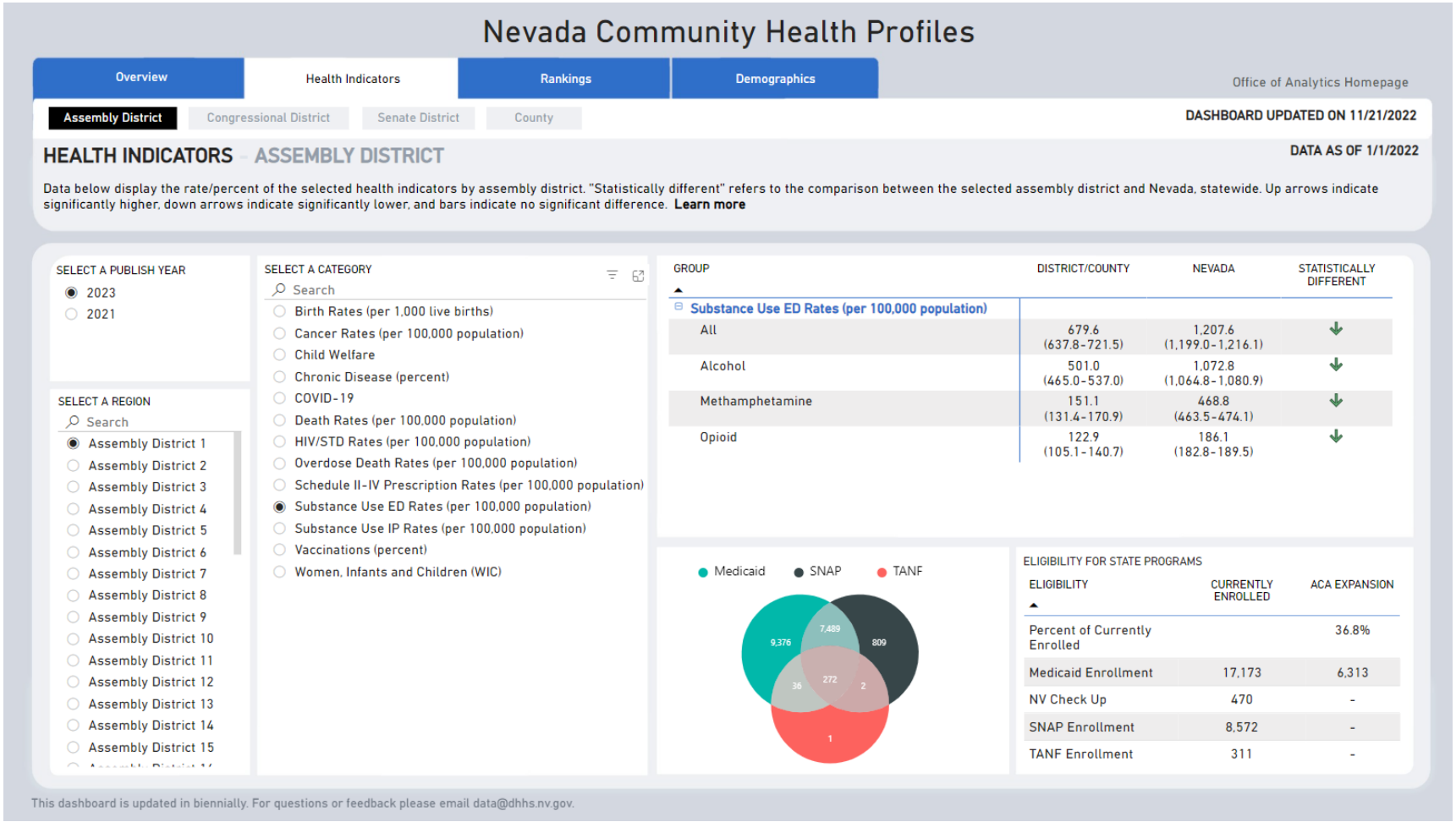
State Unintentional Drug Overdose Reporting System (SUDORS) Dashboard



[SUDORS Dashboard]

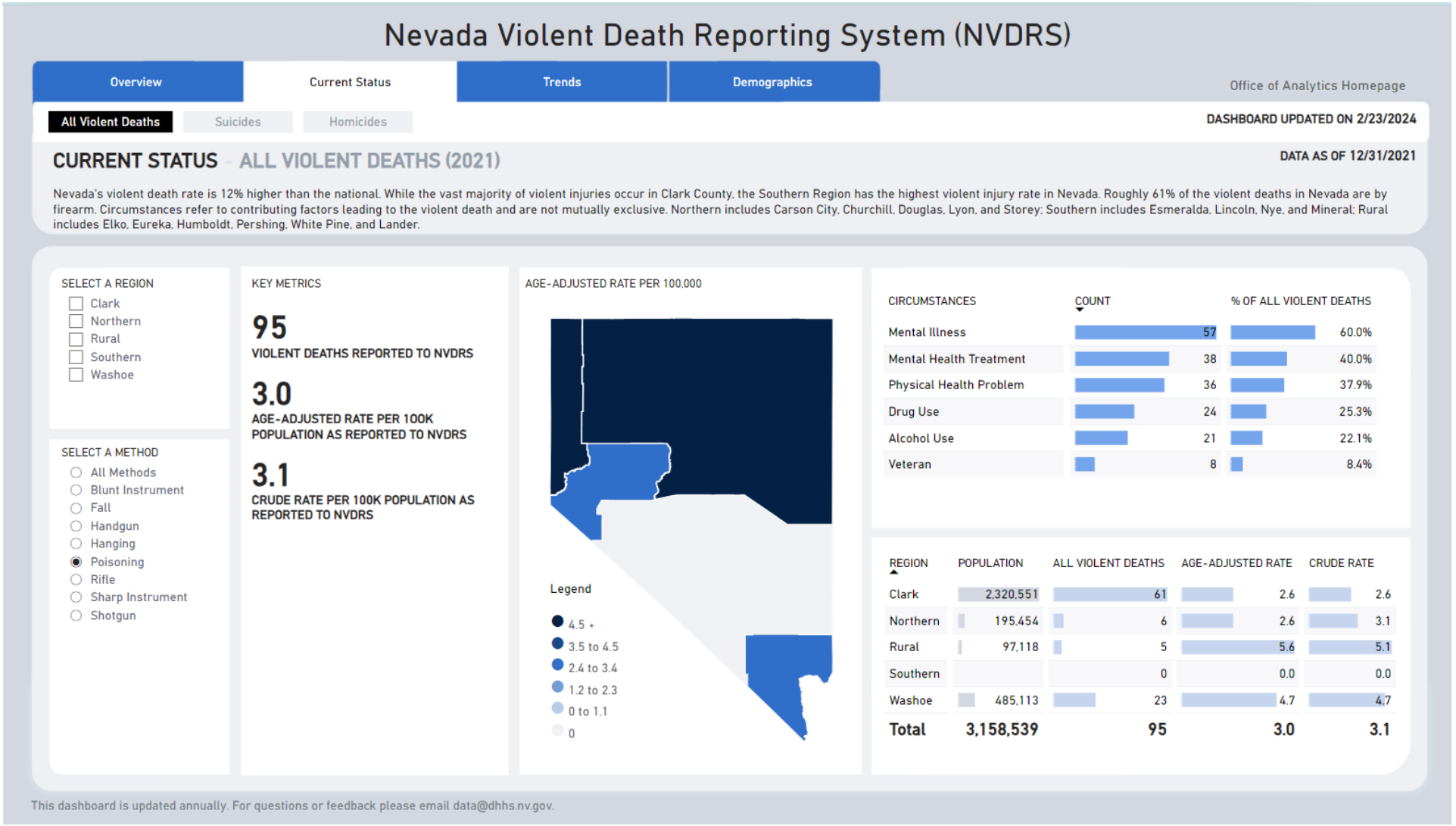
Nevada Community Health Profiles Dashboard

- Display some substance use data by assembly, congressional, and senate district or county.



[Nevada Community Health Profiles Dashboard]

Nevada Violent Death Reporting System (NVDRS) Dashboard



[NVDRS Dashboard]

Reports

- The Bureau of Behavioral Health Wellness and Prevention, Epidemiologic Profile, Nevada, 2023 for all of Nevada
  - Biennial reports
  - One for each behavioral health region as well
    - Bureau of Behavioral Health Wellness and Prevention, Epidemiologic Profile for Clark County, 2023
    - Bureau of Behavioral Health Wellness and Prevention, Epidemiologic Profile for Northern Region, 2023
    - Bureau of Behavioral Health Wellness and Prevention, Epidemiologic Profile for Rural Region, 2023
    - Bureau of Behavioral Health Wellness and Prevention, Epidemiologic Profile for Southern Region, 2023
    - Bureau of Behavioral Health Wellness and Prevention, Epidemiologic Profile for Washoe County, 2023
- State Unintentional Drug Overdose Reporting System (SUDORS) Infographic, 2022
- Veteran Suicide Report
  - Method of suicide includes opioid related overdose

Gaps and Areas of Further Study

- TEDS data dashboard (in review)
- DOSE data on SUDORS dashboard (in review)
- Tracking opioid abatement
  - FRN Program Spending/Impact (dashboard under development)
  - SOR Program Spending/Impact
- Law enforcement intelligence data
  - Example - Test impaired drivers for drugs even if they already tested positive for alcohol (not a standard practice)
- Drug Checking in Forensic labs
  - A very small % of seized drugs get tested (a court date must be schedule before drugs are tested)
  - Testing seized drugs would allow us to know what is in the drug supply
- All-Payer Claims Database (APCD)
  - Could be used to generate insights about individuals who receive a substance use diagnosis or treatment through private providers

Questions?

Contact Information

Natalie Bladis
Biostatistician III
n.bladis@dhhs.nv.gov

Kyra Morgan
Chief Biostatistician
data@dhhs.nv.gov

https://dhhs.nv.gov/Programs/Office_of_Analytics/DHHS_Office_of_Analytics/

Appendix D

Clark County Opioid Task Force

Terry Kerns

Nevada Office of the Attorney General

Substance Abuse/Law Enforcement Coordinator

Objectives

- Understand SURG structure, mandates, and reporting
- Be aware of other agencies working opioid matters
- Be aware of opioid reporting
- Understand guidelines/toolkits

NRS 458.460 Establishes Statewide Substance Use Response Working Group (SURG) in Attorney General's Office

Section 10 of this bill requires the Working Group to comprehensively review various aspects of substance misuse and substance use disorders and programs and activities to combat substance misuse and substance use disorders in this State.

Section 10.5 of this bill requires the Department of Health and Human Services to annually report to the Working Group concerning the use of state and local money to address substance misuse and substance use disorders, and

Section 10 requires the Working Group to study, evaluate and make recommendations concerning the use of that money.

http://ag.nv.gov/About/Administration/SURG_Info_Page/

SURG Membership
18 members

AG appointments

1) One representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is 700,000 or more, (
2) One representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is 100,000 or more but less than 700,000,
3) One representative of a local governmental entity that provides or oversees the provision of human services in a county whose population is less than 100,000,
4) One provider of health care with expertise in medicine for the treatment of substance use disorders,
5) One representative of the Nevada Sheriffs' and Chiefs' Association, or its successor organization,
6) One advocate for persons who have substance use disorders and family members of such persons,
7) One person who is in recovery from a substance use disorder,
8) One person who provides services relating to the treatment of substance use disorders,
9) One representative of a substance use disorder prevention coalition,
10) One representative of a program to reduce the harm caused by substance misuse
11) One representative of a hospital, and
12) One representative of a school district.

Other Appointees

13) AG appointee,
14) DHHS Director appointee,
15) NV Senate appointee,
16) NV Assembly appointee,
17) NV Assembly Minority Leader of the Assembly appointee, and
18) NV Senate Minority Leader appointee

SURG Mandates

(a) Leverage and expand efforts by state and local governmental entities to reduce the use of substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants, and identify ways to enhance those efforts through coordination and collaboration.

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

SURG Mandates continued

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(d) Work to understand how residents of this State who are involved in the criminal justice system access supports for treatment of and recovery from substance use disorders at various points, including, without limitation, by reviewing existing diversion, deflection and reentry programs for such persons.

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

(g) Make recommendations to entities including, without limitation, the State Board of Pharmacy, professional licensing boards that license practitioners, other than veterinarians, the State Board of Health, the Division, the Governor and the Legislature, to ensure that controlled substances are appropriately prescribed in accordance with the provisions of NRS 639.2391 to 639.23916, inclusive.

SURG Mandates continued

(h) Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

(i) Develop strategies for local, state and federal law enforcement and public health agencies to respond to and prevent overdoses and plans for implementing those strategies.

(j) Study the efficacy and expand the implementation of programs to:

(1) Educate youth and families about the effects of substance use and substance use disorders; and

(2) Reduce the harms associated with substance use and substance use disorders while referring persons with substance use disorders to evidence-based treatment.

(k) Recommend strategies to improve coordination between local, state and federal law enforcement and public health agencies to enhance the communication of timely and relevant information relating to substance use and reduce duplicative data collection and research.

SURG Mandates continued

(l) ***Evaluate current systems for sharing information between agencies regarding the trafficking and distribution of legal and illegal substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants.***

(m) ***Study the effects of substance use disorders on the criminal justice system, including, without limitation, law enforcement agencies and correctional institutions.***

(n) ***Study the sources and manufacturers of substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants, and methods and resources for preventing the manufacture, trafficking and sale of such substances.***

(o) ***Study the effectiveness of criminal and civil penalties at preventing the misuse of substances and substance use disorders and the manufacture, trafficking and sale of substances which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants.***

(p) ***Evaluate the effects of substance use disorders on the economy of this State.***

SURG Mandate continued

(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;

(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;

(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;

(4) The use of the money described in section 10.5 of this act to improve racial equity; and

(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

SURG Subcommittees

- 1) Prevention (primary, secondary, and tertiary) and included discussion around harm reduction strategies
  - (a) Leverage and expand efforts by state and local governmental entities to **reduce the use of substances which are associated with substance use disorders**, including, without limitation, heroin, other synthetic and non-synthetic opioids, and stimulants, and identify ways to enhance those efforts through coordination and collaboration.
  - (g) Make recommendations to entities including, without limitation, the State Board of Pharmacy, professional licensing boards that license practitioners, other than veterinarians, the State Board of Health, the Division, the Governor, and the Legislature, to **ensure that controlled substances are appropriately prescribed** in accordance with the provisions of NRS 639.2391 to 639.23916, inclusive
  - (j) Study the efficacy and expand the implementation of programs to: (1) **Educate youth and families about the effects of substance use and substance use disorders**;
- Harm Reduction
  - (j) Study the efficacy and expand the implementation of programs to: (2) **Reduce the harms associated with substance use and substance use disorders** while referring persons with substance use disorders to evidence-based treatment.

SURG Subcommittees

- 2) Treatment and Recovery
  - (c) **Assess and evaluate existing pathways to treatment and recovery** for persons with substance use disorders, including, without limitation, such persons who are members of special populations.
  - (e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures, and strategies to **treat and support recovery from opioid use disorder and any co-occurring substance use disorder**, including, without limitation, among members of special populations.
  - (f) **Examine support systems and programs for persons who are in recovery** from opioid use disorder and any co-occurring substance use disorder.

SURG Subcommittees

- 3) Response

- (d) Work to understand how residents of this State who are involved in the criminal justice system access supports for treatment of and recovery from substance use disorders at various points, including, without limitation, by **reviewing existing diversion, deflection, and reentry programs** for such persons.
- (i) Develop **strategies for local, state, and federal law enforcement and public health agencies to respond to and prevent overdoses** and plans for implementing those strategies.
- (k) Recommend strategies to **improve coordination between local, state, and federal law enforcement and public health agencies** to enhance the communication of timely and relevant information relating to substance use and reduce duplicative data collection and research.
- (l) **Evaluate current systems for sharing information between agencies regarding the trafficking and distribution of legal and illegal substances** which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids, and stimulants.
- (m) **Study the effects of substance use disorders on the criminal justice system**, including, without limitation, law enforcement agencies and correctional institutions.
- (n) **Study the sources and manufacturers of substances which are associated with substance use disorders**, including, without limitation, heroin, other synthetic and non-synthetic opioids and stimulants, and methods and resources for preventing the manufacture, trafficking, and sale of such substances.
- (o) **Study the effectiveness of criminal and civil penalties at preventing the misuse of substances and substance use disorders and the manufacture, trafficking and sale of substances** which are associated with substance use disorders, including, without limitation, heroin, other synthetic and non-synthetic opioids, and stimulants.
- (p) **Evaluate the effects of substance use disorders on the economy of this State**.

SURG Subcommittees

- Cross cutting across all SURG subcommittees

- (b) **Assess evidence-based strategies for preventing substance use and intervening to stop substance use,** including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to: (1) Help persons at risk of a substance use disorder avoid developing a substance use disorder; (2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;
- (h) **Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use, and substance use disorders, focusing on special populations**.
- (q) **Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders,** with a focus on: (1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending; (2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions; (3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth; (4) The use of the money described in section 10.5 of this act to improve racial equity; and (5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

Other Groups addressing Substance Use Disorder

- Advisory Committee on a Resilient Nevada (ACRN)
- Fund for a Resilient Nevada (FRN)
  - FRN Home (nv.gov)
- Southern Nevada Opioid Advisory Council (SNOAC)
  - Southern Nevada Opioid Advisory Council – Southern Nevada Health District
- Southern Nevada Harm Reduction Alliance
- Opioid Needs Assessment and State Plan
  - Nevada Opioid Needs Assessment and Statewide Plan 2022 (nv.gov)

Reporting

- Department of Health and Human Services (DHHS) Office of Analytics
- Fatality Reporting
- ODMAP/EMS/Hospital (Suspected Overdoses and/or non-fatal overdose reporting)
- Law Enforcement/Intelligence Reporting
- Drug Checking Reports
- Opioid Mapping for funds
  - What funds are used for
  - Specific funds are designated for specific usages
- One Nevada Agreement (One Nevada Agreement on Opioid Recoveries with Sig Pages (nv.gov))
- SURG annual report https://ag.nv.gov/About/Administration/SURG_Info_Page/
- Statewide Overdose Data to Action The Overdose Data to Action Program - Nevada State Opioid Response (nvopioidresponse.org)

Guiding Principles/Toolkits

- Evidence-based practices
  - What they are
  - Why they work
- Implementation resources
  - Toolkits
  - Guidelines
  - References to research

Legislative Analysis and Public Policy Association (LAPPA) 2023 State of the States Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment

Ten evidence-based policy approaches to reduce overdoses

- Strategy 1: Syringe services programs
- Strategy 2 & 3: Fentanyl test strips and other drug checking equipment
- Strategy 4: Medication for addiction treatment in correctional settings

LAPPA 2023 State of the States Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment

- Strategy 5: Withdrawal management services in correctional settings
- Strategy 6: School response to drug related incidents
- Strategy 7: Naloxone in public high schools
- Strategy 8: Substance use treatment in the emergency department
- Strategy 9: Substance use during pregnancy and family care plans
- Strategy 10: Overdose fatality review teams

LAPPA 2023 State of the States Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment

- Nevada adopted 5-6 strategies

LAPPA 2023 State of the States Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment

- Strategies Nevada adopted
  - STRATEGY 1: SUPPORT EXPANDED ACCESS TO SYRINGE SERVICES PROGRAMS
  - STRATEGY 2: DO NOT SUBJECT FENTANYL TEST STRIPS TO DRUG PARAPHERNALIA PENALTIES &
  - STRATEGY 3: DO NOT SUBJECT DRUG CHECKING EQUIPMENT THAT TESTS FOR DRUGS OTHER THAN FENTANYL TO DRUG PARAPHERNALIA PENALTIES
  - STRATEGY 4: REQUIRE ACCESS TO MEDICATION FOR ADDICTION TREATMENT IN STATE OR LOCAL CORRECTIONAL SETTINGS
  - STRATEGY 6: A DRUG-RELATED INCIDENT THAT OCCURS AT SCHOOL SHOULD NOT NECESSARILY BE REPORTED TO LAW ENFORCEMENT
  - STRATEGY 9: ASSIST PREGNANT OR POSTPARTUM INDIVIDUALS WITH SUBSTANCE USE DISORDER IN SEEKING HELP BY HAVING SPECIFIC LAWS/REGULATIONS DESIGNED TO HELP FAMILIES WITH SUBSTANCEEXPOSED INFANTS; AND NOT AUTOMATICALLY CONSIDERING SUBSTANCE USE DURING PREGNANCY, OR GIVING BIRTH TO A SUBSTANCE-EXPOSED INFANT, TO BE CHILD ABUSE OR NEGLECT

LAPPA 2023 State of the States Legislative Roadmap for Reducing Overdose Deaths and Increasing Access to Treatment

- Strategies Nevada has not adopted
  - STRATEGY 5: REQUIRE STATE AND LOCAL CORRECTIONAL SETTINGS TO PROVIDE WITHDRAWAL MANAGEMENT SERVICES
  - STRATEGY 7: REQUIRE ALL PUBLIC HIGH SCHOOLS TO STORE NALOXONE ON SITE FOR RESPONDING TO OVERDOSES AT SCHOOL AND AT SCHOOL-SPONSORED EVENTS
  - STRATEGY 8: INCREASE ACCESS TO SUBSTANCE USE TREATMENT IN EMERGENCY DEPARTMENT SETTINGS
  - STRATEGY 10: SUPPORT INFORMATION SHARING WITH OVERDOSE FATALITY REVIEW TEAMS

Guiding Principles/Toolkits

- Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States | Drug Overdose | CDC Injury Center
- Opioid-Settlement-Toolkit-Final-cobranded.pdf (preventchildabuse.org)
- Principles for the Use of Funds from the Opioid Litigation | JHSPH
- States' and Localities' Opioid Settlement Spending Plans & News — Opioid Settlement Tracker
- 2023 State of the States: Legislative Roadmap (legislativeanalysis.org)

Questions ????

- Terry Kerns
- Nevada Office of the Attorney General
- tkerns@ag.nv.gov
- 775 335-5172

Appendix D

Southern Nevada Opioid Advisory Council

PRESENTED BY Jessica Johnson and Jamie Ross

Overview

- Introduction to the SNOAC
- The Four Pillar Structure
- Gaps and Recommendations

Structure of the SNOAC

Last updated April 15th, 2024

Leadership

Group leadership sets the agenda coordinates meeting speakers, meeting locations and develops and sends out Ad-Hoc Updates

Executive Committee

The Executive committee meets monthly and guides the priorities and discussion points of the SNOAC

General

Meets quarterly to learn from each other and converses on topics surrounding substance use and overdose in our community. Also asks questions of programs presenting and encourages accountability

Mission and Leadership

Mission

The mission of the Southern Nevada Opioid Advisory Council (SNOAC) is to develop a systems-level response to the Southern Nevada substance use crisis through evidence-based strategies and unique community collaborations

Group Leadership:

Co-Chairs

Jessica Johnson

Southern Nevada Health District

Jamie Ross

PACT Coalition

Secretary

Katarina Pulver

Southern Nevada Health District

Executive Committee

- Southern Nevada Health District
- NV HIDTA
- PACT Coalition
- Chamberlain University
- LGBTQ Center of Southern Nevada
- LVMPD
- Office of Attorney General
- Desert Hope
- There is No Hero In Heroin (TINHIH)
- CrossRoads of Southern Nevada
- Behavioral Health Group
- Foundation for Recovery

General Committee

The Four Pillars

The SNOAC has a four-pillar approach to addressing the substance use crisis in Southern Nevada that is rooted in our guiding principles.

Prevention

Aim to apply interventions in our community that reduce risk factors and increase protective factors surrounding substance use and prevention

Examples of Community Prevention:

- Reduce barriers to comprehensive, evidence-based preK-12 primary prevention education
- Identify and fund alternative activities for youth
- Engage in overdose prevention and education strategies in higher education and faith communities
- Targeted media campaign on fentanyl risk
- ACES Prevention
- Expanding childcare
- Improve neighborhood conditions
- Improve reading ability before 5th grade

Rescue

Interventions and approaches that are implemented after substance misuse has already developed and are aimed at preventing overdose and improving quality of life and health while using substances

Examples of Community Rescue Response:

- Purchase naloxone to expand rapid access
- Need a sustainable source of funding
- Purchase harm reduction supplies and expand syringe service programs
- Support housing first approach
- Community-wide media campaign on stigma
- Harm reduction in nightclubs
- Expand drug testing and peer mentorship

Treatment

Aimed at helping individuals to end their chaotic relationship with substance use and reduce drug seeking behaviors.

Examples of Community Treatment:

- Support state-led treatment initiatives
- Support providers to move to a "treatment on demand" model
- Develop targeted media strategy on evidence-based treatment and linkage to care
- Fund drug court to incorporate evidence-based practices
- Improve policies and procedures for FQHC or primary care
- Increase number of mental health professionals
- *No wrong door approach*
- Timely/ quick access to MOUD
- Expand MOUD access to incarcerated populations

Recovery

Interventions and approaches that support a person-centered model building on the strengths and resilience of individuals, families, and communities to achieve and maintain self-defined recovery through improved health, wellness, and quality of life.

Examples of Community Recovery:

- Expand sober living/ recovery housing
- Review neighborhood and community policies to ensure they support people in recovery
- Develop media campaign on reducing stigma for people in recovery
- Expand recovery-friendly workplace initiatives
- Alumni group expansion

Guiding Principles

The SNOAC develops its systems-level approach on a foundation of health equity, community, data, evaluation, social determinants of health, and accountability.

Health Equity	Everyone deserves a chance to be healthy by addressing barriers like poverty, discrimination, powerlessness, and lack of access to good jobs, education, housing, safe environments, and healthcare.
Community	People organized around a shared interest or reducing substance use and overdose in the community. This community is mobilized and advocating for change in Clark County though traditional and non-traditional grassroots partnerships.
Data	The Southern Nevada Opioid Advisory Council believes in science and supports strategies that address substance use and overdose that are evidence-based, peer-reviewed approaches
Evaluation	Projects that are supported by SNOAC are empowered to collect and share out data on the results of their projects so that our community can learn about successful approaches in the Clark County community

Guiding Principles

The SNOAC develops its systems-level approach on a foundation of health equity, community, data, evaluation, social determinants of health, and accountability.

Social Determinants of Health

Nonmedical factors such as employment, income, housing, transportation, childcare, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.

The SNOAC defines the Social Determinants of Health as:

- Structural and Institutional Racism and Discrimination
- Housing
- Neighborhood Conditions
- Education
- Income

Accountability

SNOAC engages in three types of accountability- democratic accountability, performance accountability and financial accountability.

Identified Community Projects – 2023

Pre-K through 12 evidence-based primary prevention education- equip all schools in Clark County with the resources and staffing to implement evidence-based primary prevention education

Harm Reduction Supplies- prioritize purchase of harm reduction supplies unallowable through federal funds

Public health co-response for overdose prevention- Support law enforcement real-time overdose efforts with a 24/7 public health team to address overdose prevention and referral for services

Service provider loop- comprehensive transit system drives around the service provider route continuously and picks people up at designated loading and unloading zones

One-Stop Shop/No Wrong Door- Create a person-centered community education plan and "service directory" ensuring every substance use resource knows where to access what clients need

Recommendations

Continue to support evidence-based community efforts to drive change

---

Utilize best practice frameworks for task force structure and decision making

---

Prioritize approaches and interventions that save lives

SAVE THE DATE

2024
SOUTHERN NEVADA SUBSTANCE MISUSE AND OVERDOSE PREVENTION SUMMIT

Thursday, August 1
8:00a-5:00p

Tuscany Suites & Casino
255 E Flamingo Rd.
Las Vegas, NV 89169

Be a part of the 2024 Southern Nevada Substance Misuse and Overdose Prevention Summit where we will focus on addressing and prioritizing the evolving needs of the community in response to the changing landscape of the overdose crisis.

Stay up to date with this event by registering your interest at https://bit.ly/SNSMOPSInterest or contact Katarina Pulver, the Event Coordinator, at pulver@snhd.org

Call for Workshops Now Open!

Learn more and submit proposals at https://bit.ly/2024SNSMOPSCallforWorkshops

Appendix F

togetherforbetter

Opioid Task Force Meeting

04.18.2024

CCOCME

- Responsible for death investigations.
  - Purpose of this investigation is to determine the medical cause and manner of death
  - Establish the circumstances of death
  - Identify the decedent
  - Locate and Notify the LNOK
  - Report information for public health and safety

Facts about our team

- Coroner/Assistant Coroner
- Currently have 4 FT forensic pathologists
- Administration Section
- Forensics Section
- Investigations Section
- Others (instructors, Locum Tenens)
- 1 Chaplain

Accreditation Standards

Deaths are categorized as being one of the designated manners:

- Natural
- Accident
- Suicide
- Homicide
- Undetermined

Determining the CAUSE of deaths

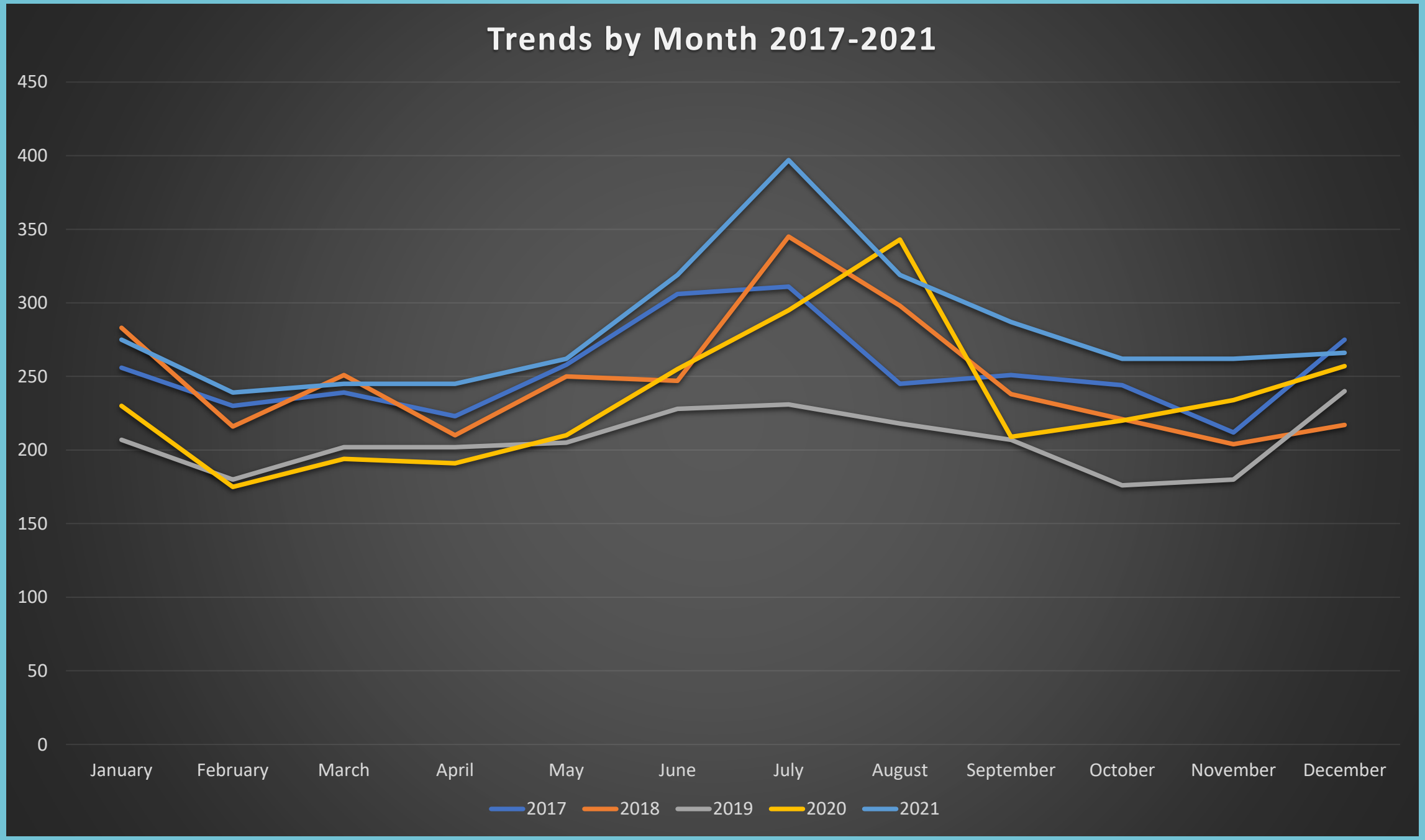
arteriosclerosis, diabetes mellitus, sul nyxia, congestive heart failure, squamous cell carcinoma, hyperthermia, sepsis, amy s, drowning, acute myocardial infarction, Sudden Unexplained Infant Death, gunshot tion, peritonitis, respiratory distress syndrome, hanging, melanoma, chronic obstructive pulmonary disease, stabbing, epilepsy, duodenal ulcer, peripheral vascular disease, organic brain sy noid hemorrhage, ischemic bowel obstruction, strangulation, hydrocephalus, electrocu blunt force trauma, perforated ulcer, liver cirrhosis, cerebrovascular accident, intrauterine fetal demise, exposure, leukemia, Parkinson's disease, malnutrition, hip fracture, adenocarcinoma, ruptured spleen, acquired immune deficiency syndrome, poisoning, gastroenteritis, pulmonary embolism, acetaminophen toxicity, carbon monoxide, urosepsis, viral hepatitis, transient ischemic attacks, blunt force head trauma, abdominal aortic aneurysm, hypertension, phencyclidine hydrochloride, osteomyelitis, sequela of morbid obesity, neuroblastoma, lymphoma, ketoacidosis, hanging, staphylococcus meningitis, encephalopathy, pancreatitis, malignant melanoma, hyperkalemia, acute renal failure, septal defect, myocardial infarction, cholecystitis, anaphylactic shock, pneumonia, sickle-cell anemia, multisystem organ failure

Why does it take so long?

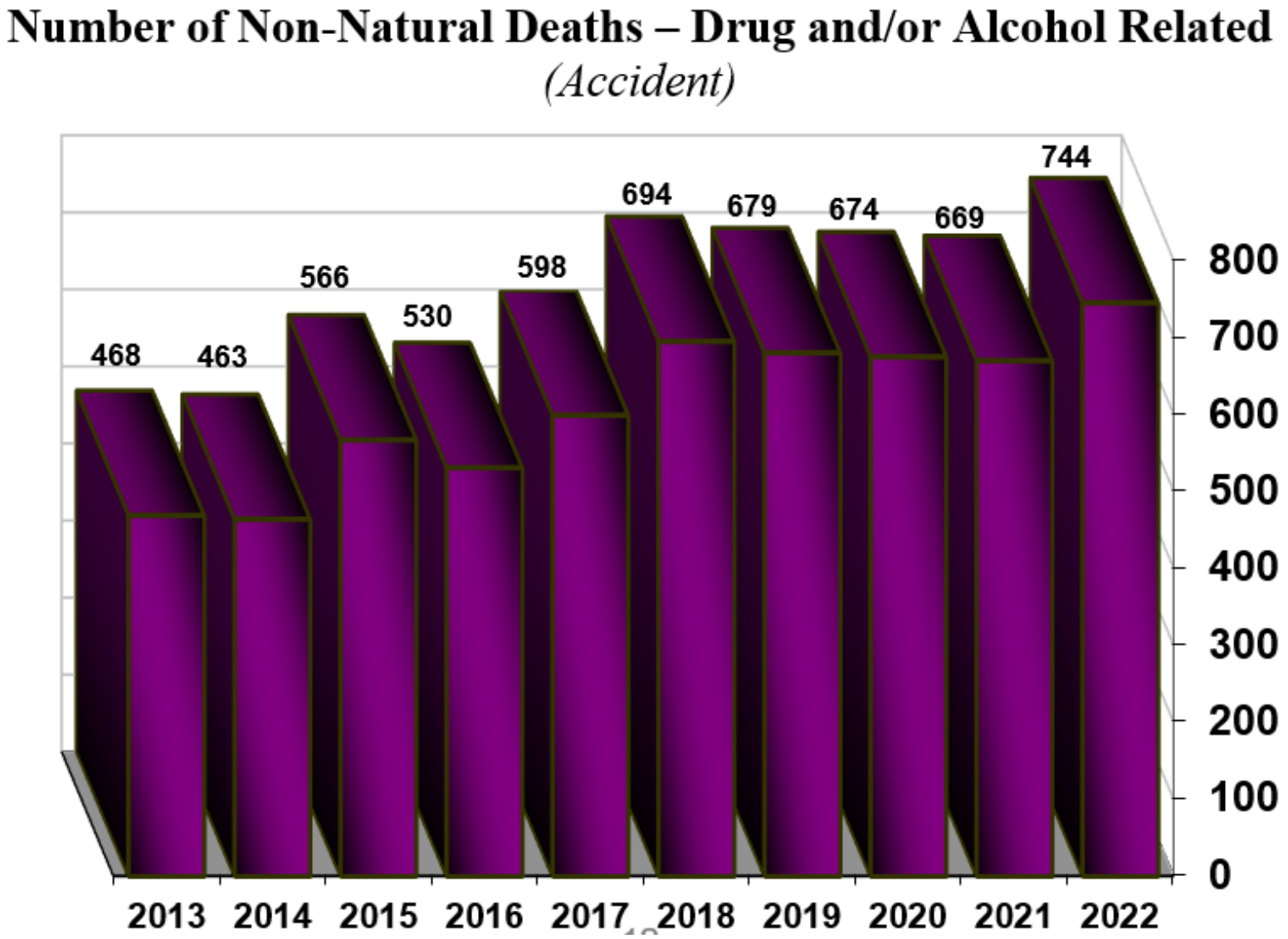
- >90% of cases are completed in 90 days
- Case complexity
- Requests for documents and records
  - Medical Records
  - Police Reports
  - Other agency requests
- Requests for ancillary testing
  - Toxicology
  - Histology
  - Genetics
  - Special Consultations

Volume (2022)

- 22,452 total deaths in Clark County
- ~7894 Deaths reported
- ~5343 Jurisdictional cases
- ~3524 Postmortem examinations
- ~10000+calls/month
- >453 Social Service referrals
- >371 organ donation approvals, 254 tissue, 287 ocular donors


Trends by Month 2017-2021
450
400
350
300
250
200
150
100
50
0
January
February
March
April
May
June
July
August
September
October
November
December
2017
2018
2019
2020
2021

Accidental Deaths



Worldwide Shortage of Forensic Pathologists

- Worldwide Shortage of these Medical Experts
- Job Openings vs. Qualified Applicants
- The combination of these issues has pushed the profession to its capacity.
- Retiring professionals.
- Funding
- **Result is More locums (contractors) than ever**
  - 142/933 or 15% of practicing FPs are part-time per 2023 NAME data.

Comprehensive Death Investigations

- Examination (Autopsy, Medical Exam)
- Investigation
- Toxicology
- Review of full investigation
- Certification of Death
- Issuance of a report

National Association of Medical Examiners (NAME)

- Autopsy provides the best information about a decedent's medical condition for optimal interpretation of toxicology results, circumstances surrounding death, medical history, and scene findings
- Scene investigation includes reconciling prescription information and medication counts. Investigators should note drug paraphernalia or other evidence of using intoxicating substances.
- When death is attributed to a drug or combination of drugs (as cause or contributing factor), the certifier should list the drugs by generic name in the autopsy report and death certificate

Investigative Process

- **Thorough and Systematic Medicolegal Death Investigation of the body and the incident scene,** *to include but not limited to:*
- **Prescription medication**
  - Prescribed to ? - *i.e. to the decedent or another*
  - Location, relation to other medications/RX
  - Type and amount prescribed/amount on hand
  - Same Rx prescribed by more than one physician
  - Hx of normal ingestion, stockpiling…
  - Recent indicators (suicidal ideations/attempts)
  - Evidence of accidental ingestion or misuse (crushing, paraphernalia, etc.)
- **H&P** – ER records, inpatient admissions, physician notes, etc. to include prescribed/administered Rx (when, type, quantity/means)
- **Pharmacy dispense logs**
- **State prescription drug monitoring database**
- **Illicit Drugs**
- **Toxicology analysis/results**

Scene findings suggesting opioid misuse

- Opioid medications
- Evidence of drug use (Paraphernalia)
- Evidence of insufflation
- Pills not stored in prescription vials or mixed in vials
- Injection sites
- Transdermal patches
- Presence of naloxone

Findings from Autopsy

- Autopsy findings sometimes suggesting a history of illicit drug or substance use
- Lung edema and froth in airway
- Natural Disease Burden
- NOTHING

What's Next?

- Quick urine analysis
  - quick screening test of urine
  - Screening tests alone offer generally incomplete evidence,
  - Are subject to false positives and negatives
  - Lack confirmation
  - Thus, inadequate for establishing a cause of death (NAME, 2019)
- Toxicology testing must be performed

Toxicology

- Qualitative and Quantitative is required
- Screening typically performed initially, often with ELISA or other qualitative technique
- Confirmation testing with gas or paper (thin layer) chromatography, mass spectrometry, or combination (GC-MS most common)
- Confirmation testing also quantitative as indicated

Toxicology: Specimens

Routine Specimens

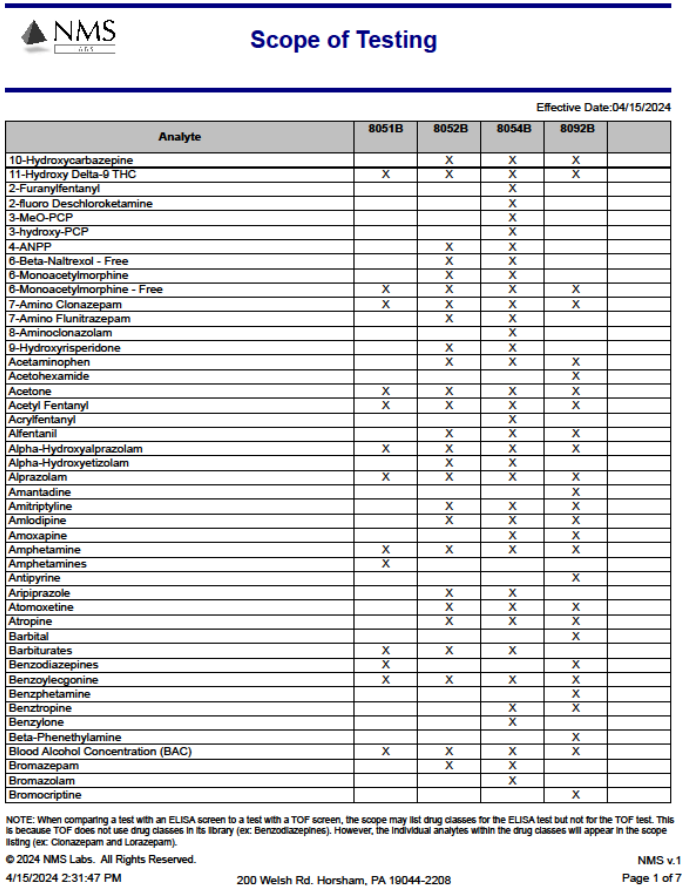
- Blood
- Vitreous fluid
- Bile
- Urine
- Liver
- Gastric contents

Alternative Specimens

- Muscle
- Spleen
- Lung
- Brain
- Kidney

Scope of Testing

- Basic
- Expanded
- Total Tox



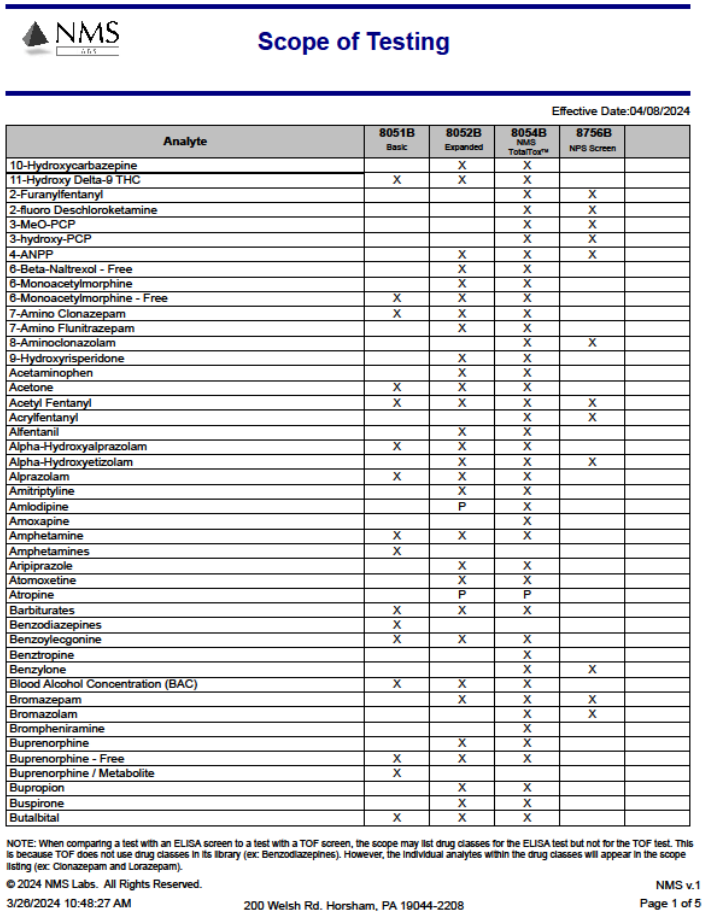
NMS

Scope of Testing

Effective Date:04/15/2024

Analyte	8051B	8052B	8054B	8092B	
10-Hydroxycarbazepine		X	X	X	
11-Hydroxy Delta-9 THC	X	X	X	X	
2-Furanylfentanyl			X		
2-fluoro Deschloroketamine			X		
3-MeO-PCP			X		
3-hydroxy-PCP			X		
4-ANPP		X	X		
6-Beta-Naltrexol - Free		X	X		
6-Monoacetylmorphine		X	X		
6-Monoacetylmorphine - Free	X	X	X	X	
7-Amino Clonazepam	X	X	X	X	
7-Amino Flunitrazepam		X	X		
8-Aminoclonazolam			X		
9-Hydroxyrisperidone		X	X		
Acetaminophen		X	X	X	
Acetohexamide				X	
Acetone	X	X	X	X	
Acetyl Fentanyl	X	X	X	X	
Acrylfentanyl			X		
Alfentanil		X	X	X	
Alpha-Hydroxyalprazolam	X	X	X	X	
Alpha-Hydroxyetizolam		X	X		
Alprazolam	X	X	X	X	
Amantadine				X	
Amitriptyline		X	X	X	
Amlodipine		X	X	X	
Amoxapine			X	X	
Amphetamine	X	X	X	X	
Amphetamines	X				
Antipyrine				X	
Aripiprazole		X	X		
Atomoxetine		X	X	X	
Atropine		X	X	X	
Barbital				X	
Barbiturates	X	X	X		
Benzodiazepines	X			X	
Benzoylecgonine	X	X	X	X	
Benzphetamine				X	
Benztropine			X	X	
Benzylone			X		
Beta-Phenethylamine				X	
Blood Alcohol Concentration (BAC)	X	X	X	X	
Bromazepam		X	X		
Bromazolam			X		
Bromocriptine				X	

NOTE: When comparing a test with an ELISA screen to a test with a TOF screen, the scope may list drug classes for the ELISA test but not for the TOF test. This is because TOF does not use drug classes in its library (ex: Benzodiazepines). However, the individual analytes within the drug classes will appear in the scope listing (ex: Clonazepam and Lorazepam).



NMS

Scope of Testing

Effective Date:04/08/2024

Analyte	8051B Basic	8052B Expanded	8054B NMS TotalTox™	8756B NPS Screen	
10-Hydroxycarbazepine		X	X		
11-Hydroxy Delta-9 THC	X	X	X		
2-Furanylfentanyl			X	X	
2-fluoro Deschloroketamine			X	X	
3-MeO-PCP			X	X	
3-hydroxy-PCP			X	X	
4-ANPP		X	X	X	
6-Beta-Naltrexol - Free		X	X		
6-Monoacetylmorphine		X	X		
6-Monoacetylmorphine - Free	X	X	X		
7-Amino Clonazepam	X	X	X		
7-Amino Flunitrazepam		X	X		
8-Aminoclonazolam			X	X	
9-Hydroxyrisperidone		X	X		
Acetaminophen		X	X		
Acetone	X	X	X		
Acetyl Fentanyl	X	X	X	X	
Acrylfentanyl			X	X	
Alfentanil		X	X		
Alpha-Hydroxyalprazolam	X	X	X		
Alpha-Hydroxyetizolam		X	X	X	
Alprazolam	X	X	X		
Amitriptyline		X	X		
Amlodipine		P	X		
Amoxapine			X		
Amphetamine	X	X	X		
Amphetamines	X				
Aripiprazole		X	X		
Atomoxetine		X	X		
Atropine		P	P		
Barbiturates	X	X	X		
Benzodiazepines	X				
Benzoylecgonine	X	X	X		
Benztropine			X		
Benzylone			X	X	
Blood Alcohol Concentration (BAC)	X	X	X		
Bromazepam		X	X	X	
Bromazolam			X	X	
Brompheniramine			X		
Buprenorphine		X	X		
Buprenorphine - Free	X	X	X		
Buprenorphine / Metabolite	X				
Bupropion		X	X		
Buspirone		X	X		
Butalbital	X	X	X		

NOTE: When comparing a test with an ELISA screen to a test with a TOF screen, the scope may list drug classes for the ELISA test but not for the TOF test. This is because TOF does not use drug classes in its library (ex: Benzodiazepines). However, the individual analytes within the drug classes will appear in the scope listing (ex: Clonazepam and Lorazepam).

Now What?

- Toxicological test results must be interpreted by a Board-Certified Forensic Pathologist
- In the context of the circumstances surrounding death, the medical history, the scene of the death, and the autopsy findings (NAME, 2019)
- Awareness to postmortem redistribution
- Tolerance
- Drug Interactions
- Other variables

How the Death Certificate is Certified

- Evaluating other contributing factors
- Determining if it is a primary, secondary, or tertiary cause of death
- Determining it is an OSC (Other significant condition contributing to death)

CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events – diseases, injuries, or complications that directly caused the death. **DO NOT** enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

		Interval
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. _____ Due to (or as a consequence of)	_____
Sequentially list condition(s), if any, leading to the cause listed on line a. enter the UNDERLYING CAUSE (disease or injury that initiated the sequence) on the lowest line	b. _____ Due to (or as a consequence of)	_____
	c. _____ Due to (or as a consequence of)	_____
	d. _____ Due to (or as a consequence of)	_____

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.

33. WAS AN AUTOPSY PERFORMED?

☐ Yes ☐ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?

☐ Yes ☐ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH?

☐ Yes ☐ Probably
☐ No ☐ Unknown

36. IF FEMALE

☐ Not pregnant within past year
☐ Pregnant at time of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Unknown if pregnant with the past year

37. MANNER OF DEATH

☐ Natural ☐ Homicide
☐ Accident ☐ Pending Investigation
☐ Suicide ☐ Could not be determined

Purpose of Part I:

- Part I is for reporting a chain of events leading directly to death, with the **immediate cause** of death (the final disease, injury, or complication directly causing death) on line (a)

- And the **underlying cause** of death (the disease or injury that initiated the chain of events that led directly and inevitably to death) on the lowest used line

- Also in Part I, the time intervals between onset of condition and death are specified (years, months, minutes or unknown duration)

Purpose of Part II:

- Part II is for reporting all other significant diseases, conditions, or injuries that contributed to death that did not result in the underlying cause of death listed in Part I.

Additional fields to be completed by the medical certifier

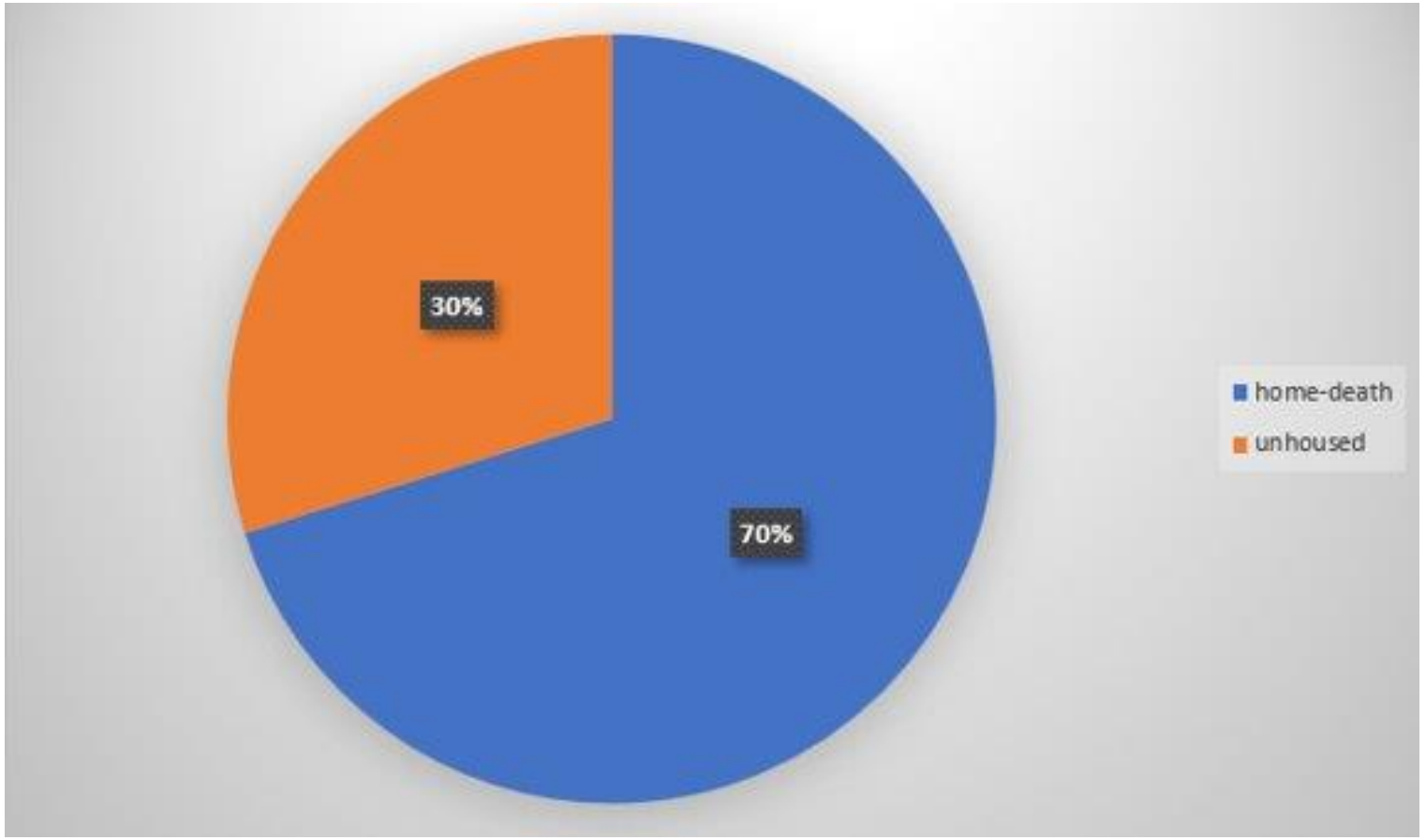
- Did tobacco use contribute to death?
- Was decedent pregnant at any time in the year previous to death?
- Were autopsy results used in the certification?
- Manner of Death – Natural, accident, suicide, homicide or undetermined
  (Most of these deaths, will be classified as “accident”)
- Date and Time of death
- Date and Time of Injury
- Location of Injury
- Signature of certifier and date signed

Data from October 1, 2023 to March 24, 2024

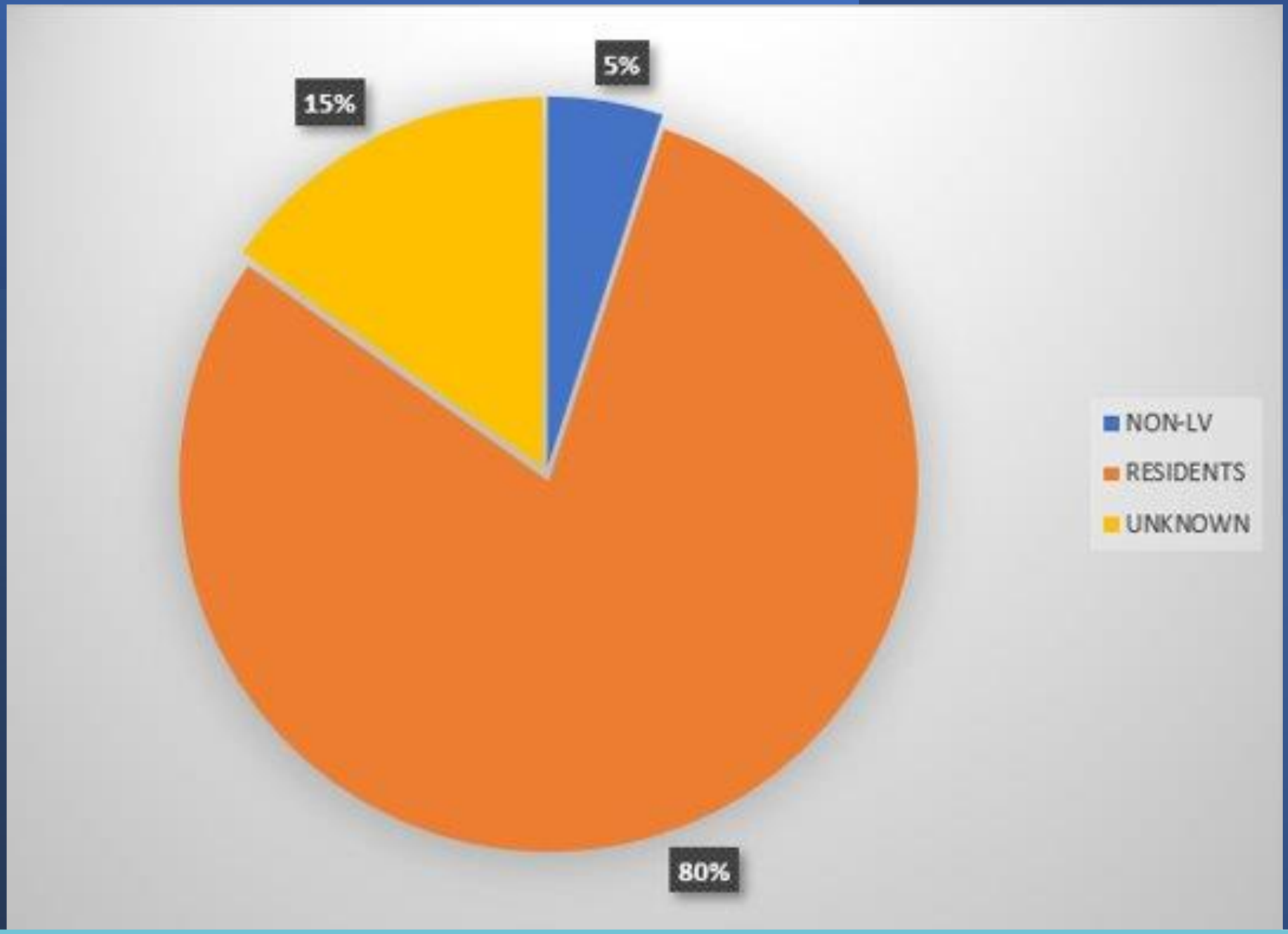
MANNER OF DEATH	COUNT OF CASE NUMBER
Accident	233
Suicide	5
Grand Total	**238**

At Home Deaths:106

Confirmed Unhoused Deaths: 45



Non-NV Residents: 12
Residents: 190

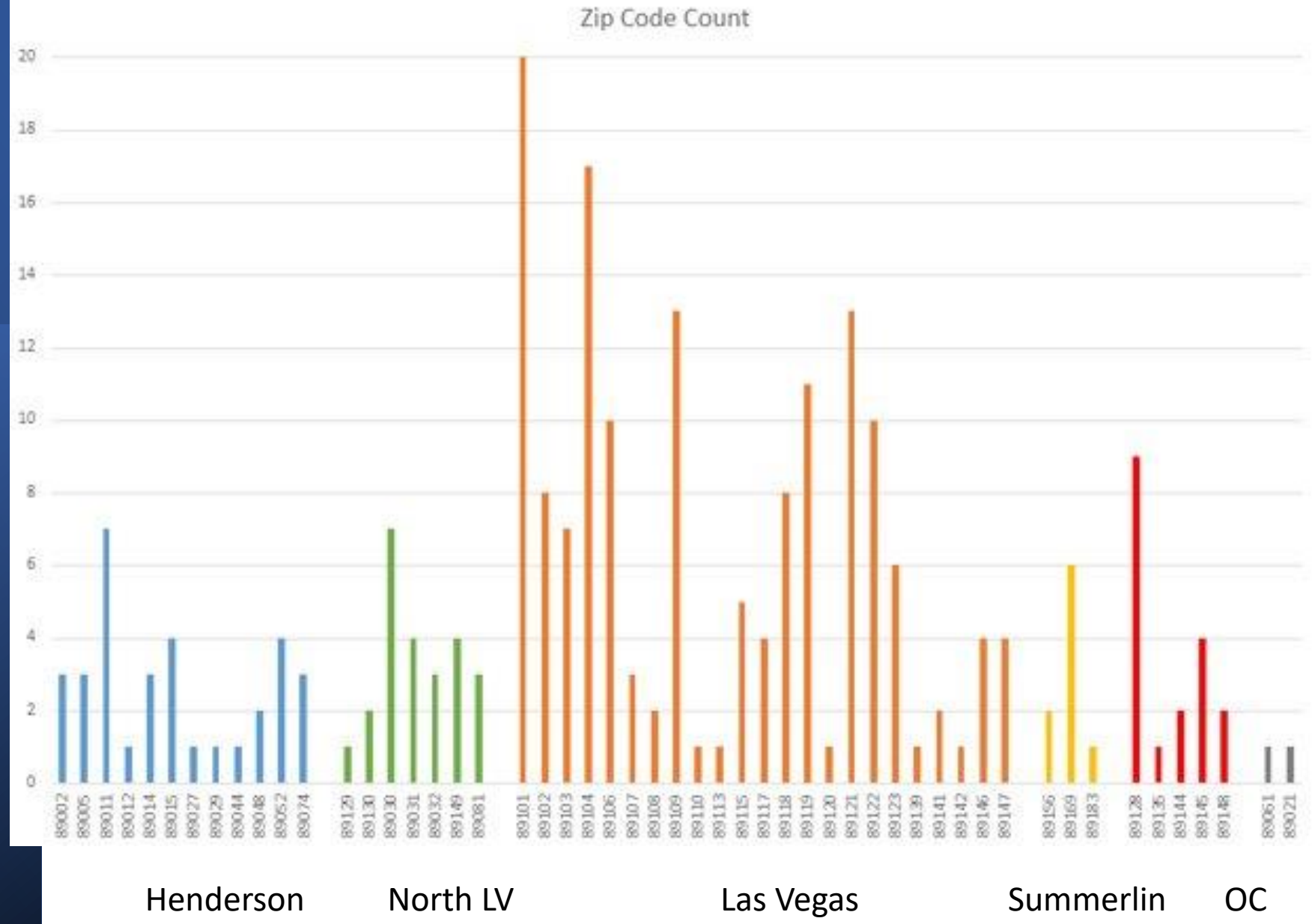


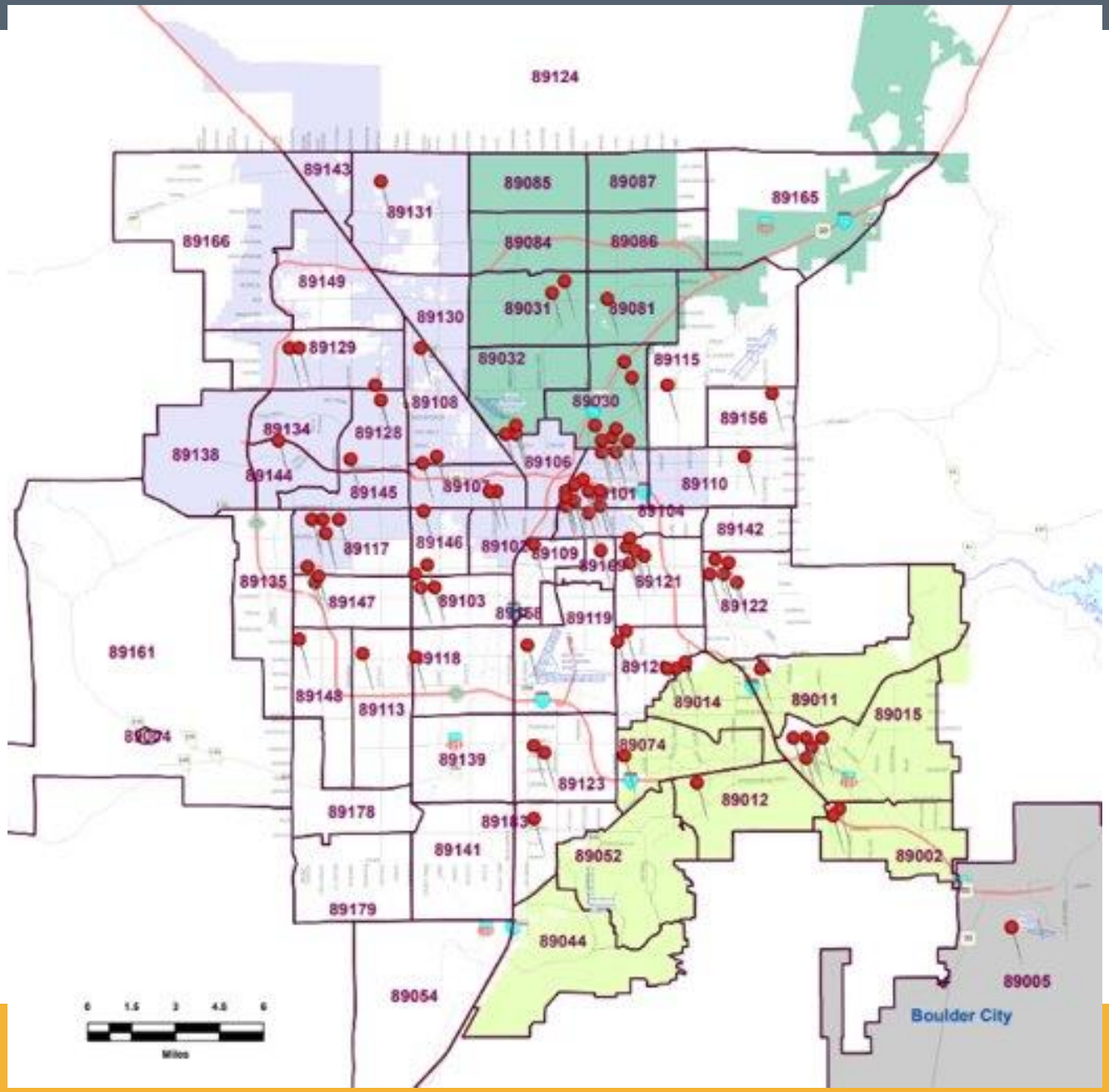
Highest:89101, 89104

High Numbers: Vegas Area

Low Numbers: North Las Vegas and Summerlin Area

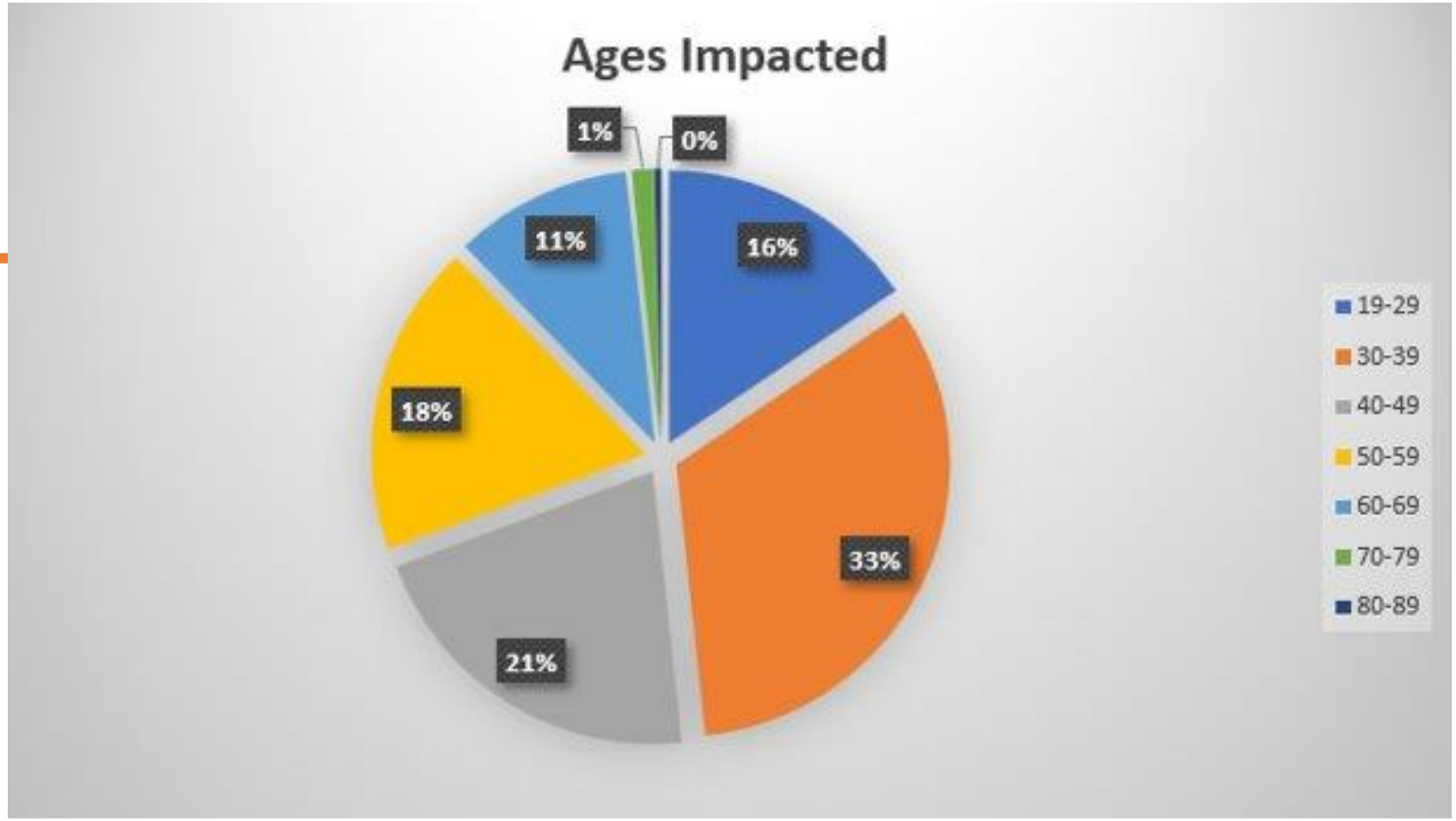
Zip Code of Incident Location




89124
89143
89131
89085
89087
89165
89166
89084
89086
89149
89031
89081
89130
89129
89032
89115
89108
89030
89156
89134
89128
89138
89106
89144
89110
89145
89107
89101
89104
89142
89117
89146
89102
89109
89135
89121
89147
89103
89122
89119
89161
89118
89148
89113
89014
89011
89015
89074
89139
89123
89012
89178
89141
89052
89002
89179
89044
89005
89054
Boulder City
0 1.5 3 4.5 6
Miles

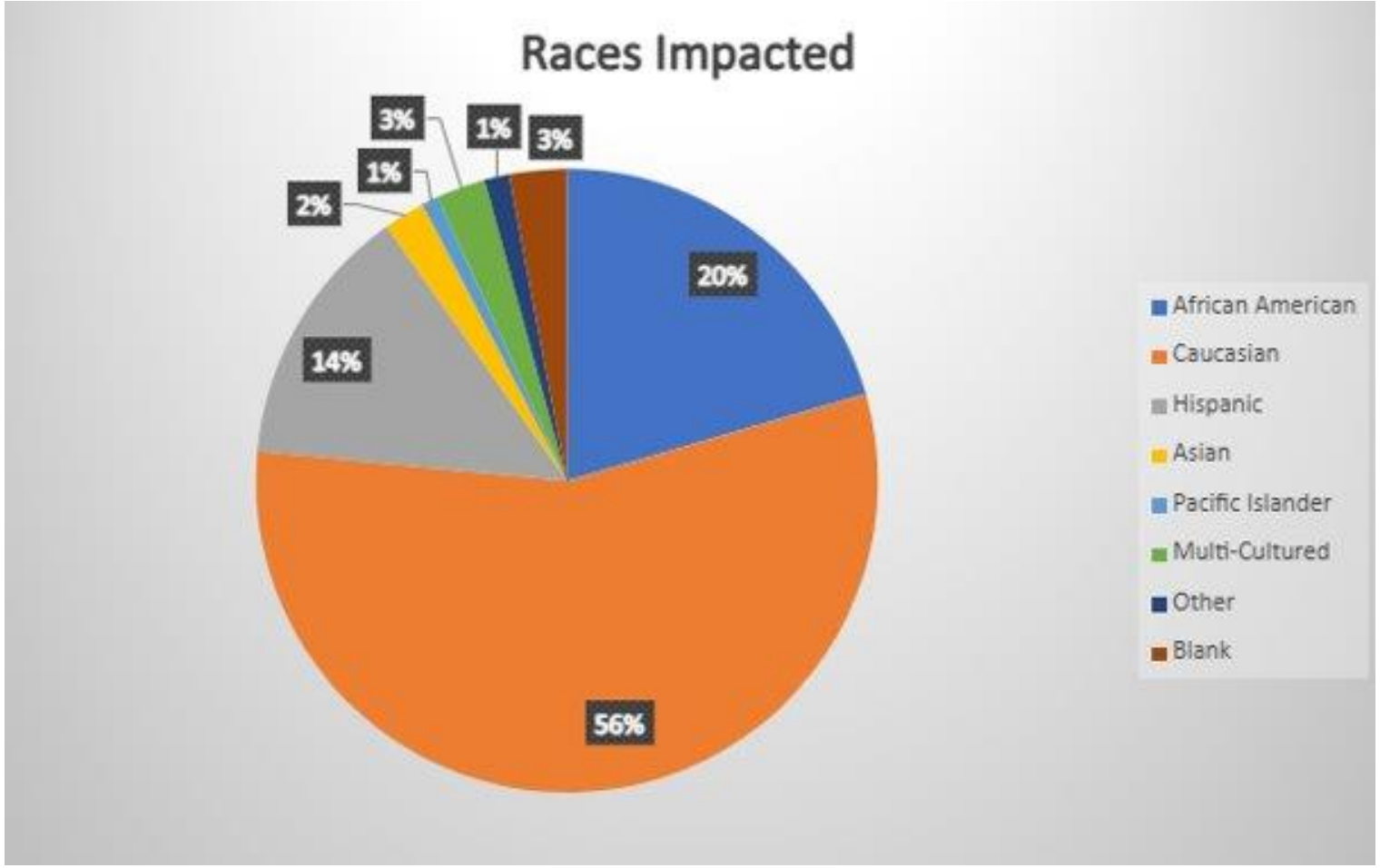
Age at time of death

- Outliers: 75- and 80-year old
- Focus: 30–39-year-old age group & 50-59 age group



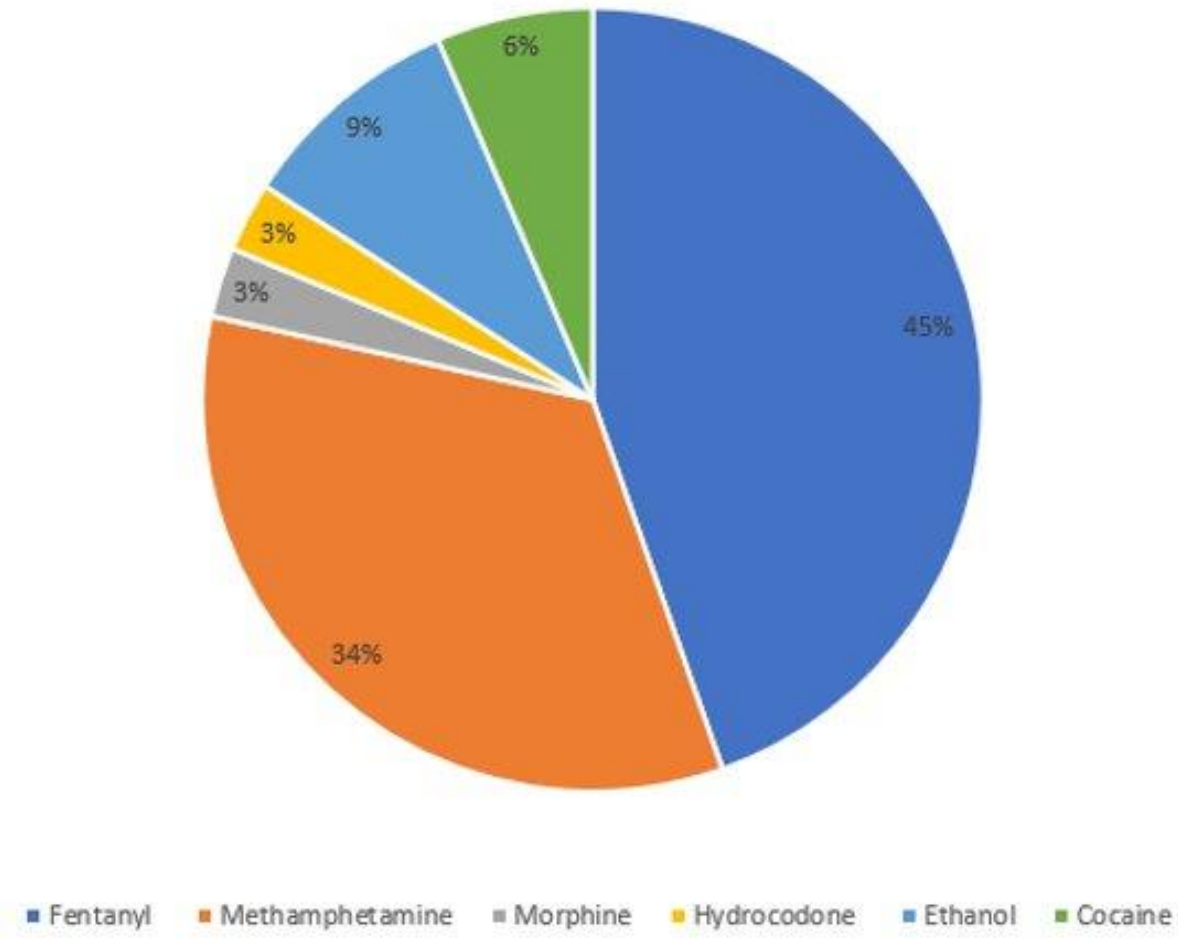
Outliers: Asians & Pacific Islanders

Focus: Caucasians, African Americans and Hispanics



Substances

- These numbers show how many cases include specific substances in the individual's toxicology.
- Most OD cases consist of a combination of multiple substances
- When drugs are not in combination it is usually Fentanyl and Oxycodone.



2024

- Jan-March we completed 5575 tests
- Turnaround time - 11days to 3 weeks
- Add-ons take longer

Highlight Case

- Carfentanil Death 0.35 ng/ml on admission blood
- DOD 3/7/2024
- Zip Code of Incident 89147
- 38 y/o White Female of Las Vegas, NV
- COD: Toxic Effects of Carfentanil
- MOD: Accident
- How Injury Occurred: Consumed illicit drug
- Hx: alcohol or illicit drug abuse, with known use of Fentanyl
- Given 2 doses of Naloxone

References

- Clark County Office of the Coroner/Medical Examiner. (n.d.). *Moon client*. Moon Client. https://clark.vertiq.us/
- Davis, G. G., Cadwallader, A. B., Fligner, C. L., Gilson, T., Hall, E., Harshbarger, K., Kronstrand, R., Mallak, C., McLemore, J., Middleberg, R. A., Middleton, O. L., Nelson, L. S., Rogalska, A., Tonsfeldt, E., Walterscheid, J., & Winecker, R. E. (2019b, December 17). Opioid position paper final 12-17-2019.PDF. https://www.thename.org/assets/docs/Opioid%20position%20paper%20Final%2012-17-2019.pdf

Appendix G

CLARK COUNTY REGIONAL OPIOID TASK FORCE INDICATORS

AN OVERVIEW OF OPIOID OVERDOSE INDICATORS IN CLARK COUNTY, NV

BRANDON DELISE

SR. EPIDEMIOLOGIST

SOUTHERN NEVADA HEALTH DISTRICT

Data Sources

Fatal Drug Overdose Indicators

EDRS: Electronic Death Registry System

Non-Fatal Drug Overdose Indicators

ESSENCE: Electronic Surveillance System for the Early Notification of Community-Based Epidemics

ESO: Emergency Medical Services Outcome Data

Other Indicators

High Intensity Drug Trafficking Areas (HIDTA) Seizures

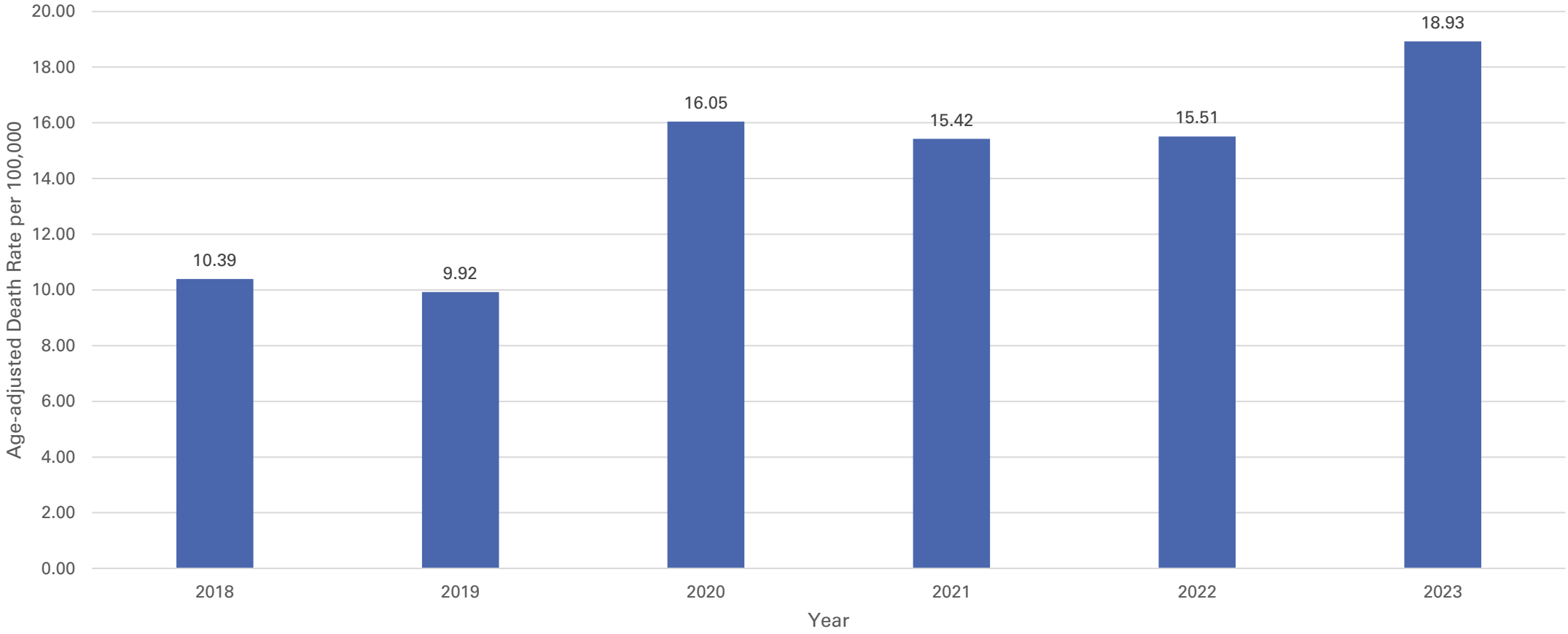
Naloxone Distributions & Administrations

Social Vulnerability Index

SECTION I: FATAL DRUG OVERDOSE INDICATORS

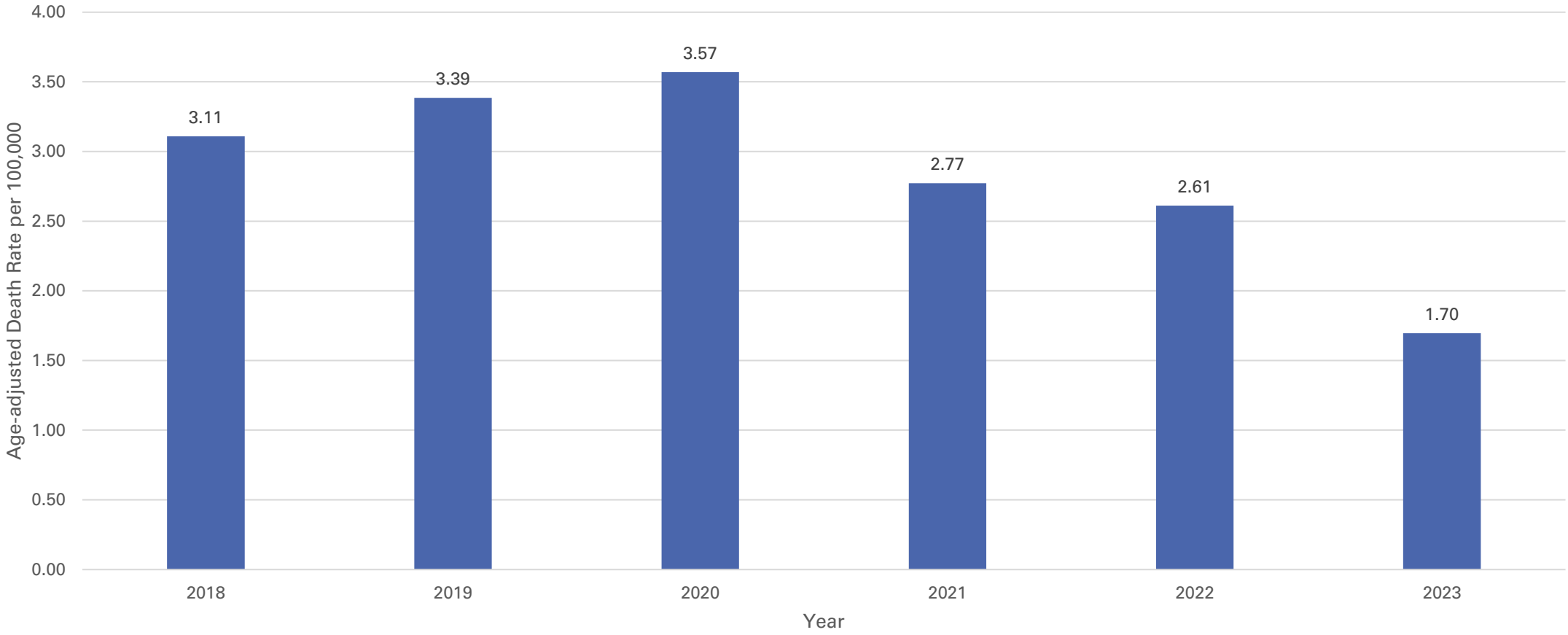
- Electronic Death Registry System
- HIDTA Seizure Reports

Age Adjusted Overdose Death Rate Involving **Any Opioid** Per 100,000 Clark County Residents, 2018 - 2023



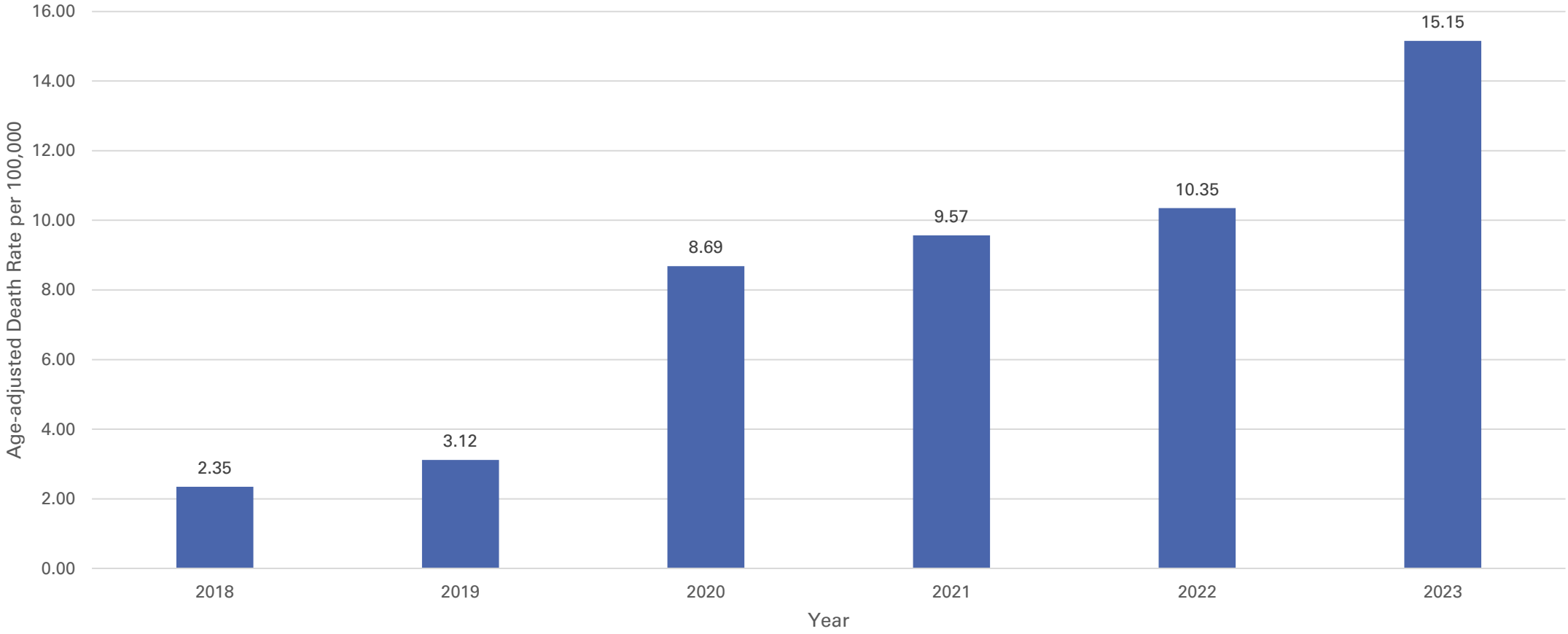
Percent change 2018-2023: Overdose death rate per 100,000 Clark County residents involving any opioid – **82.19% increase.** Data Source: Electronic Death Registry System

Age Adjusted Overdose Death Rate Involving **Heroin** Per 100,000 Clark County Residents, 2018 - 2023



Percent change 2018-2023: Overdose death rate per 100,000 Clark County residents involving heroin – **45.34% decrease.** Data Source: Electronic Death Registry System

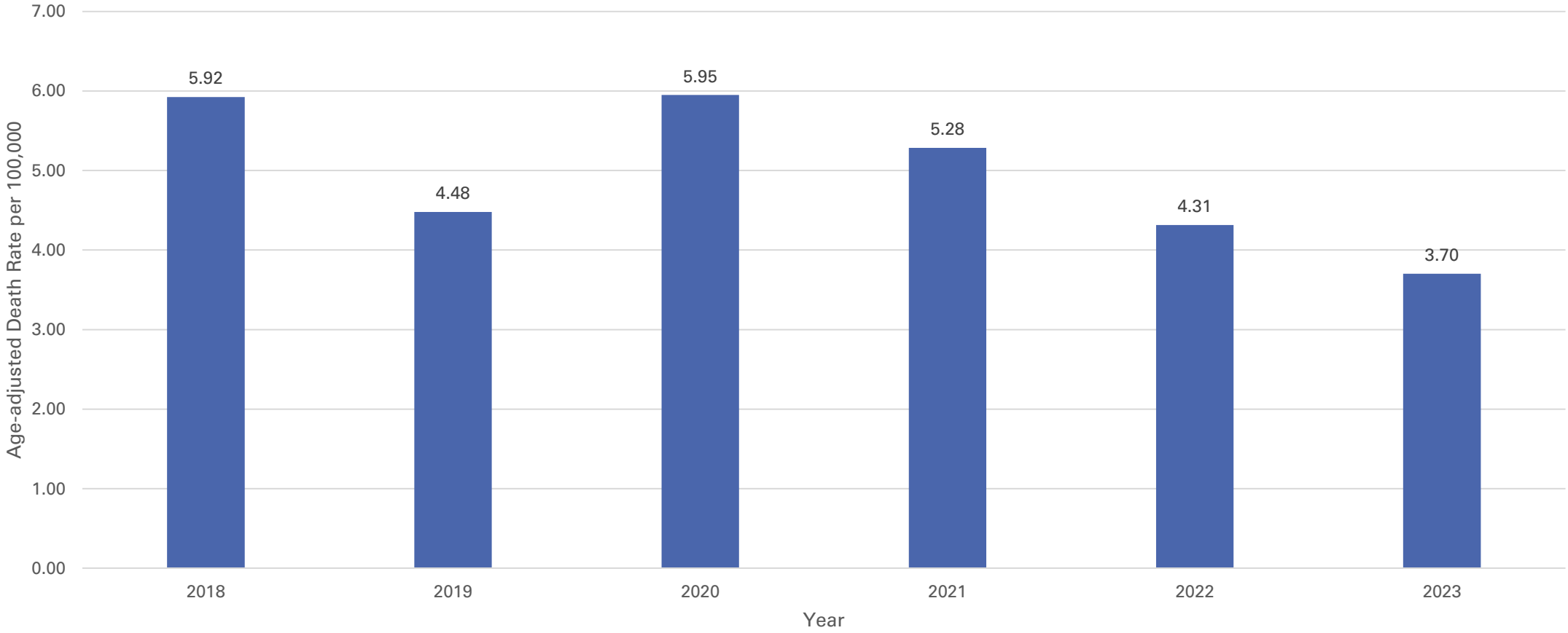
Age Adjusted Overdose Death Rate Involving **Fentanyl** Per 100,000 Clark County Residents, 2018 - 2023



Percent change 2018-2023: Count of overdose deaths involving fentanyl – **544.68% increase.**

Data Source: Electronic Death Registry System

Age Adjusted Overdose Death Rate Involving **Rx Opioids** Per 100,000 Clark County Residents, 2018 - 2023



Percent change 2018-2023: Count of overdose deaths involving Rx opioids – **37.5% decrease.**

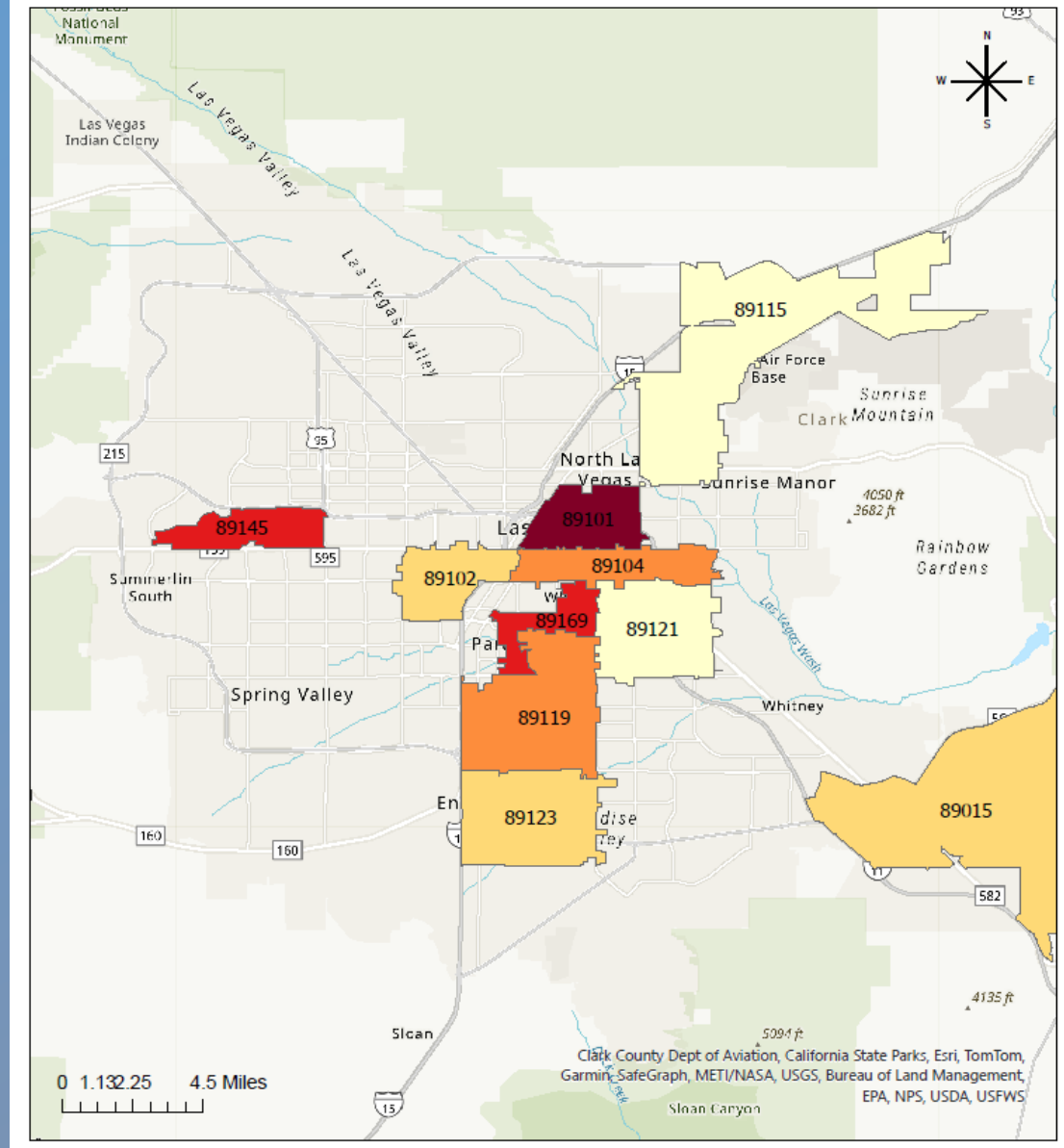
Data Source: Electronic Death Registry System

Crude Opioid Overdose Death Rate per 100,000 by Resident ZIP Code, 2023

Top 5 ZIP Codes with the Highest Crude Opioid Overdose Death Rate per 100,000, 2023	
ZIP	Death Rate per 100,000
89101	62.68
89145	46.58
89169	46.40
89104	41.00
89119	37.82
Population estimates from Southern Nevada Consensus Population Estimate, August - Roll Close 2022	

Data Source: Electronic Death Registry System

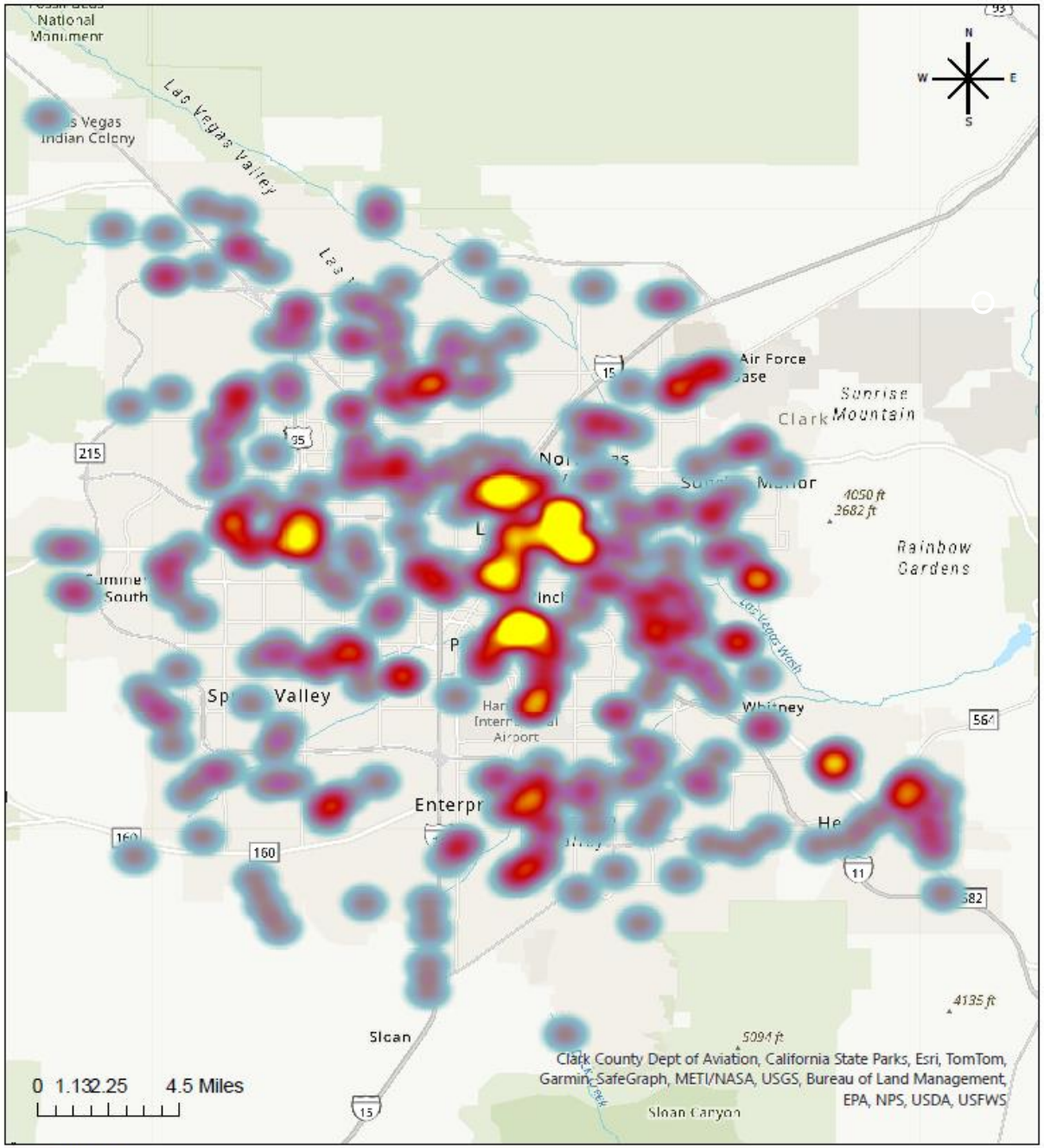
CRUDE OPIOID OVERDOSE DEATH RATE PER 100,000 BY ZIP CODE USING RESIDENTIAL ZIP CODE, 2023



Note: Rates with a numerator less than 12 have been suppressed for stability.

Data Source: Electronic Death Registry System

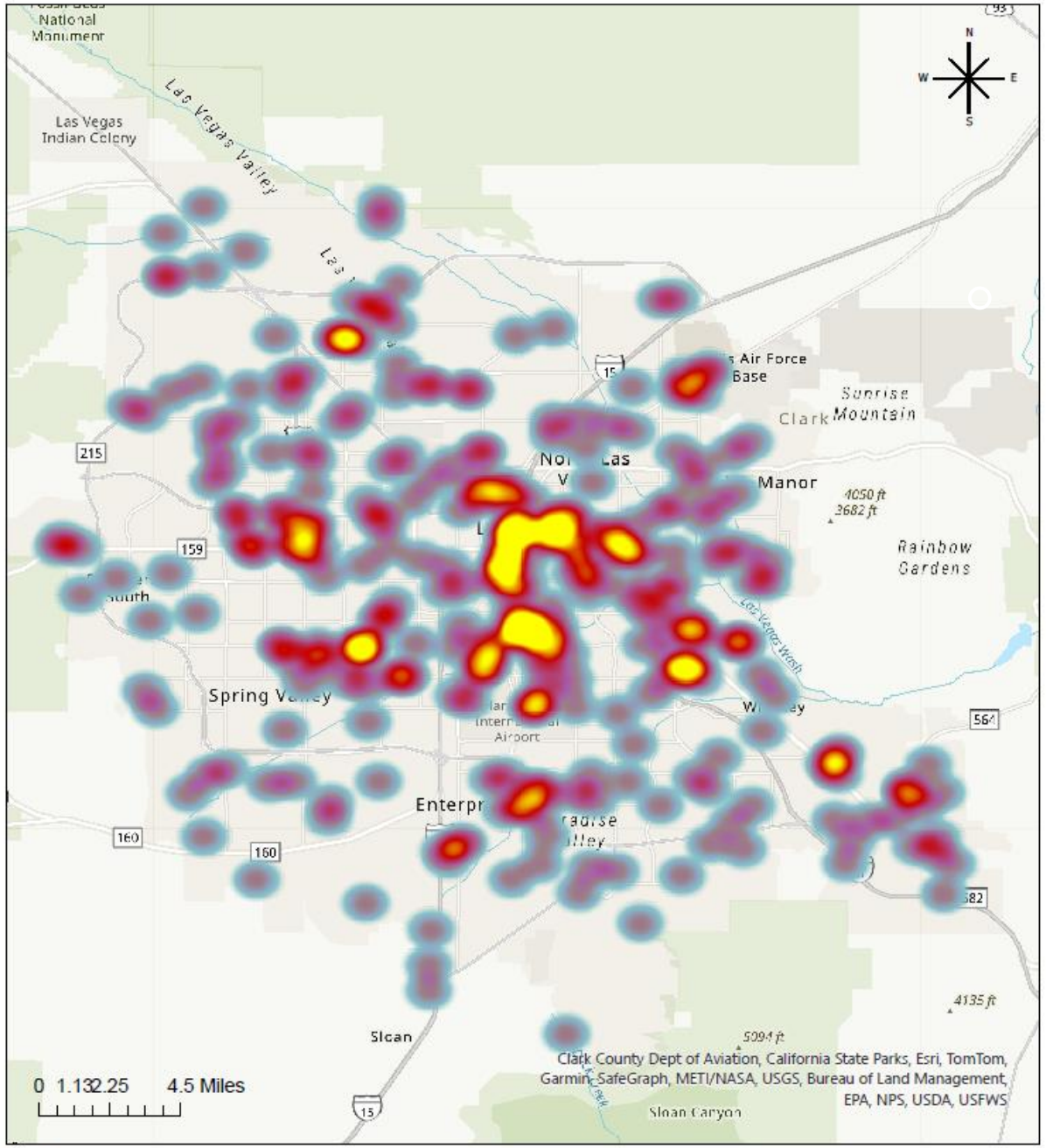
FATAL OPIOID OVERDOSE HEAT MAP USING RESIDENTIAL ADDRESS, 2023



Clusters are located Downtown, Washington & H St, and UNLV (Flamingo & Paradise).

Data Source: Electronic Death Registry System

FATAL OPIOID OVERDOSE HEAT MAP USING INJURY LOCATION, 2023



Clusters are located Downtown, 13th & Stewart, Naked City/Arts District, and UNLV.

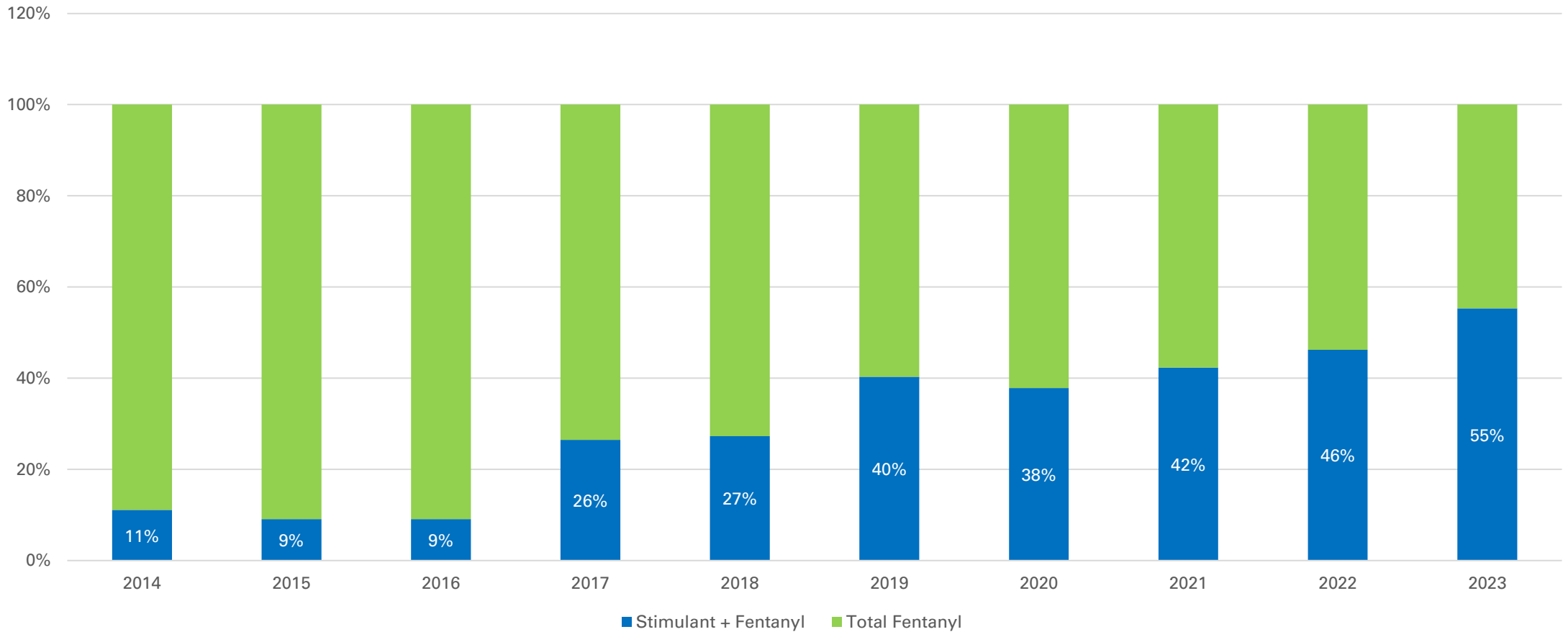
Data Source: Electronic Death Registry System

Cross Tabulation of Fatal Drug Overdoses (Counts) Involving Multiple Substances Among Clark County Residents, 2023

Drug Overdose Death Crosstabulation by Substance Among Clark County Residents, 2023							
	All Opioid	Fentanyl	Heroin	Rx Opioids	Meth	Cocaine	Benzos
All Opioid	388	302	39	81	155	48	64
Fentanyl		302	13	31	135	44	37
Heroin			39	5	18	-	-
Rx Opioids				81	15	6	28
Meth					290	25	13
Cocaine						75	5
Benzos							74
Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.							

Data Source: Electronic Death Registry System

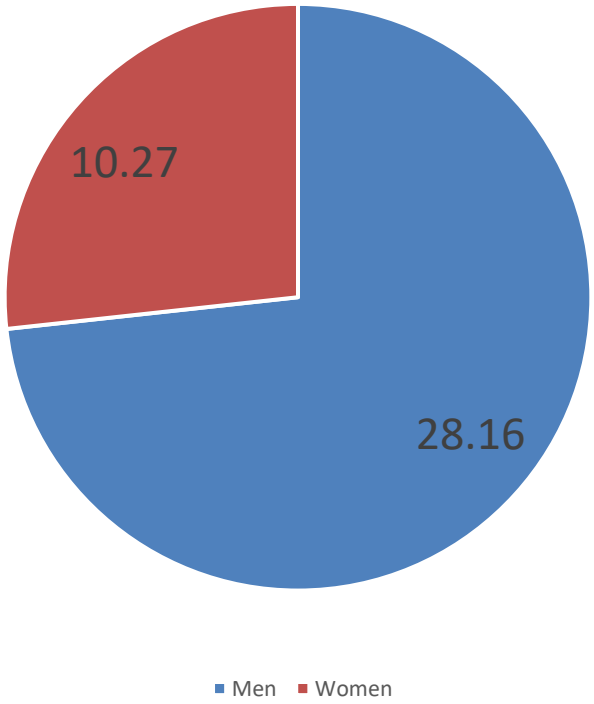
Proportion of Fentanyl Overdose Deaths Co-occurring with Stimulants (Methamphetamine and/or Cocaine) by Year, Among Clark County Residents, 2014-2023



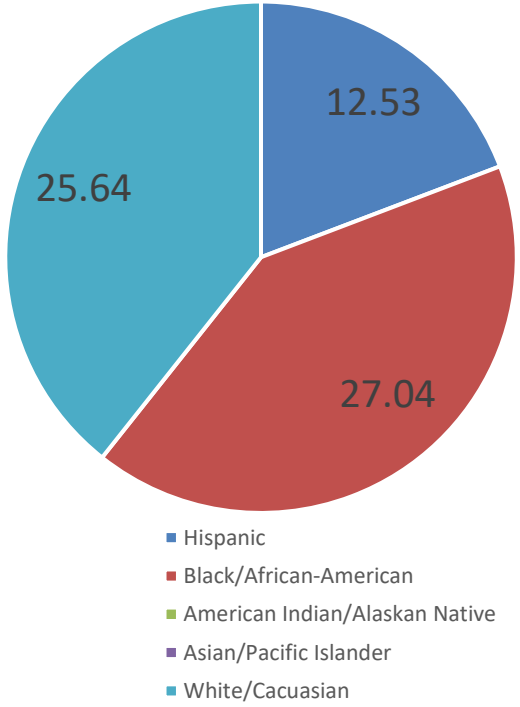
Data Source: Electronic Death Registry System

Opioid Overdose Death Descriptive Statistics Among Clark County Residents, 2023

Crude Opioid Overdose Death Rate by Gender per 100,000 Clark County Residents, 2023



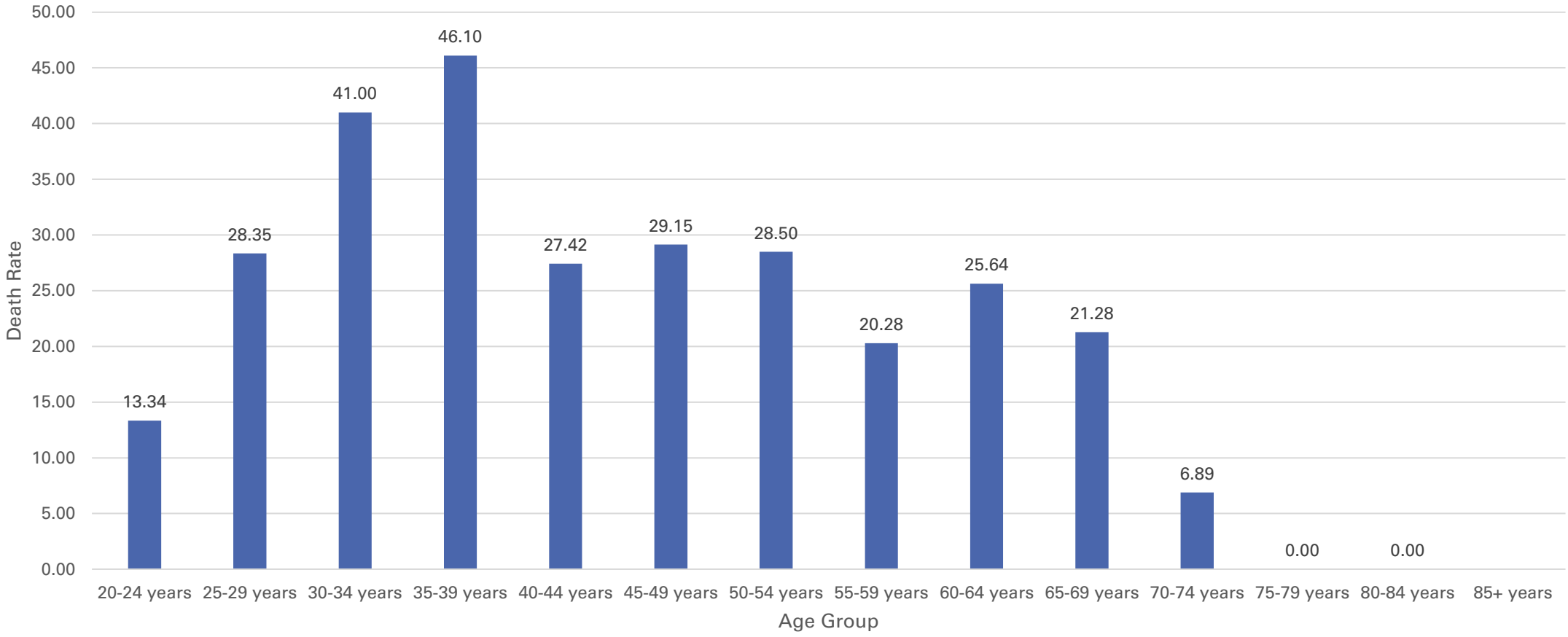
Crude Opioid Overdose Death Rate by Race/Ethnicity per 100,000 Clark County Residents, 2023



Note: Rates with a numerator less than 12 have been suppressed for reliability

Data Source: Electronic Death Registry System

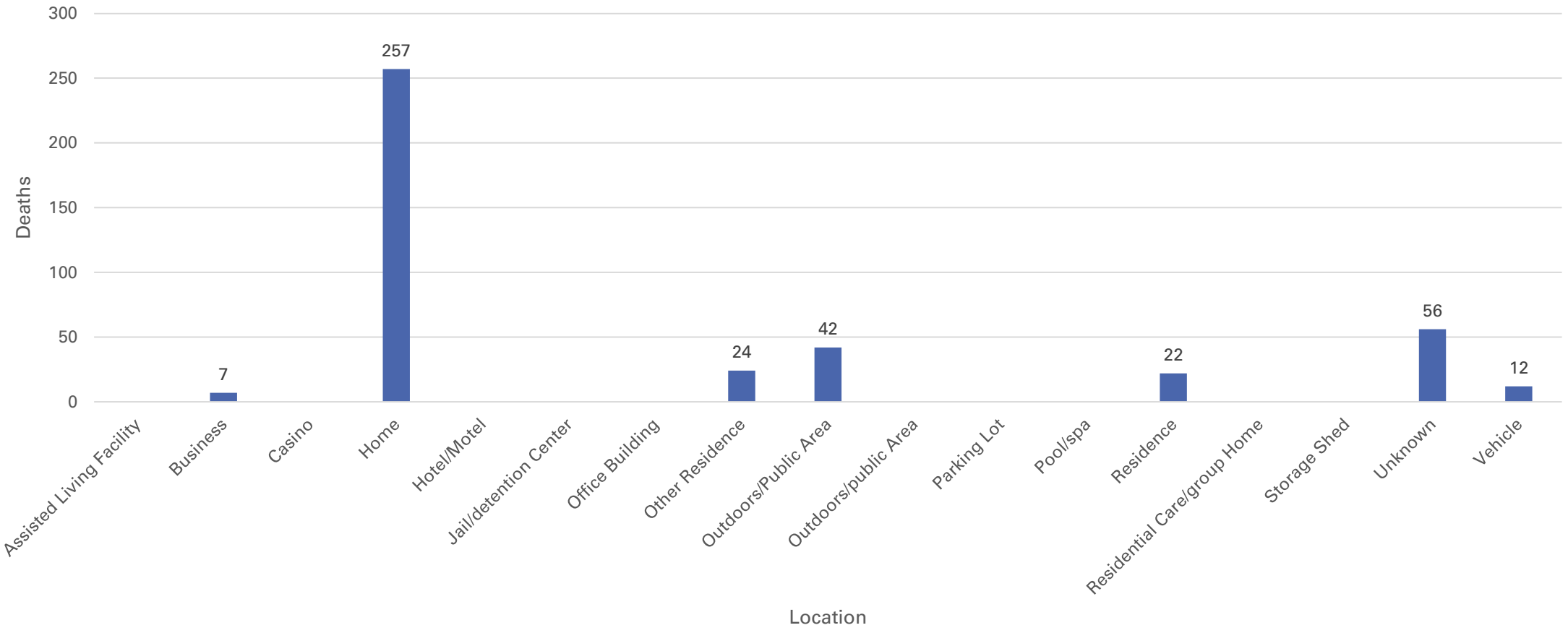
Age Specific Opioid Overdose Death Rate per 100,000 Clark County Residents, 2023



Note: Rates with a numerator less than 12 have been suppressed for reliability.

Data Source: Electronic Death Registry System

Count of Fatal Opioid Overdose Location Among Clark County Residents, 2023



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

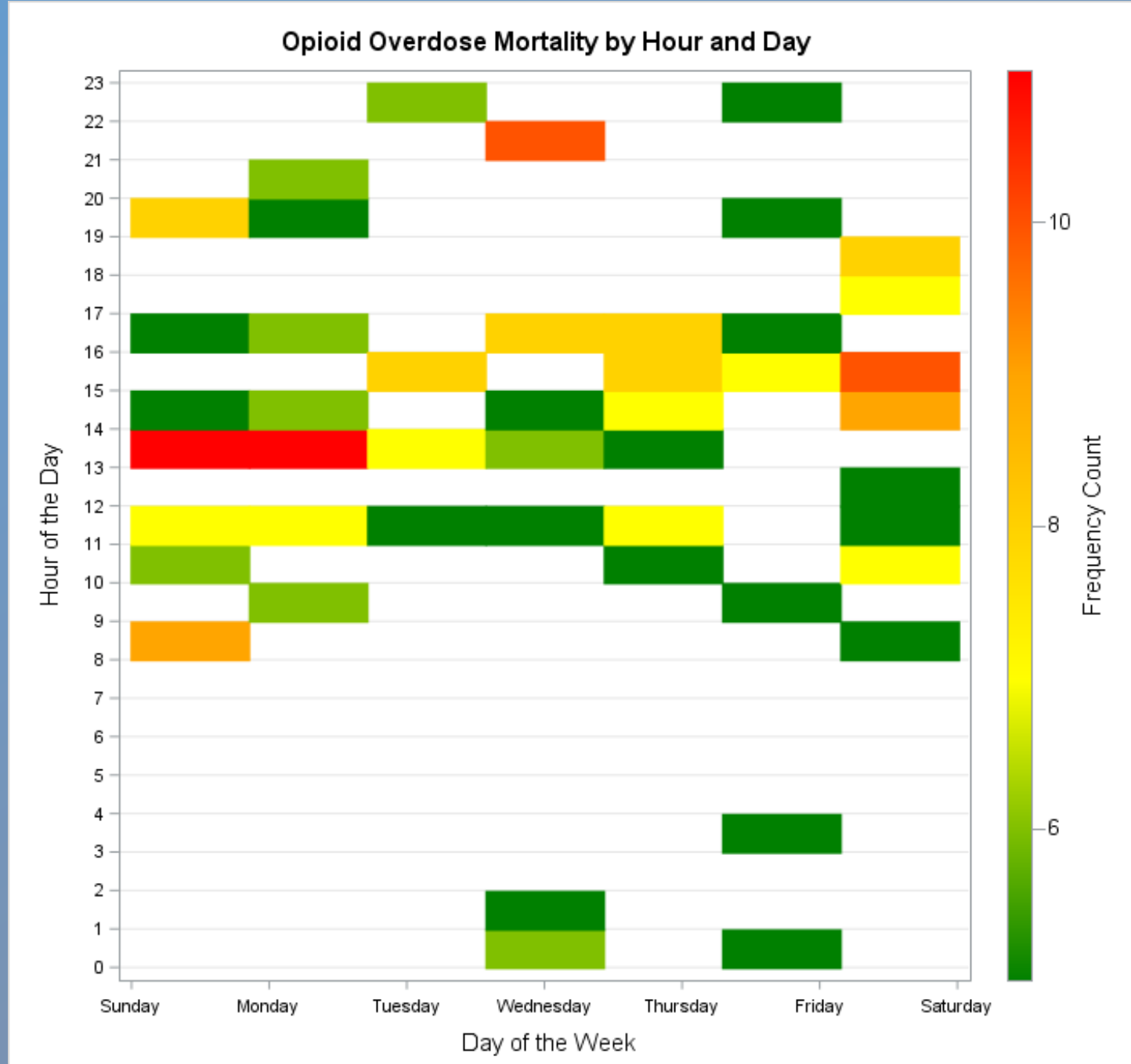
Data Source: Electronic Death Registry System

Drug Overdose Death Descriptive Data (Counts) Involving Select Substances Among Clark County Residents, Comparing 2023 Vs. 2022

	All Opioid			Fentanyl			Meth		
Date	2022	2023	% Change	2022	2023	% Change	2022	2023	% Change
Age									
Under 1 year	-	-	-	-	-	-	-	-	-
1 to 4 years	-	-	-	-	-	-	-	-	-
5 to 9 years	-	-	-	-	-	-	-	-	-
10 to 14 years	-	-	-	-	-	-	-	-	-
15 to 19 years	10	-	-	10	-	-	-	-	-
20 to 24 years	20	16	-20	16	15	-6.25	9	-	-
25 to 29 years	33	37	12.12	30	36	20.00	18	15	-16.67
30 to 34 years	46	61	32.61	33	51	54.55	31	34	9.68
35 to 39 years	64	70	9.38	39	58	48.72	47	45	-4.26
40 to 44 years	52	34	-34.62	33	30	-9.09	33	21	-36.36
45 to 49 years	28	40	42.86	17	28	64.71	39	27	-30.77
50 to 54 years	25	38	52	13	25	92.31	26	40	53.85
55 to 59 years	32	24	-25	19	19	0.00	37	34	-8.11
60 to 64 years	15	30	100	8	19	137.50	32	38	18.75
65 to 69 years	18	22	22.22	7	13	85.71	15	27	80.00
70 to 74 years	7	5	-28.57	6	-	-	6	-	-
75 to 79 years	-	-	-	-	-	-	-	-	-
80 to 84 years	-	-	-	-	-	-	-	-	-
85 years and over	-	-	-	-	-	-	-	-	-
Race									
Hispanic	74	84	13.51	58	75	29.31	54	58	7.41
Black	60	66	10	45	57	26.67	47	54	14.89
AI/AN	-	-	-	-	-	-	-	-	-
Asian/PI	8	5	-37.5	5	-	-	8	11	37.50
White/Caucasian	203	221	8.87	118	156	32.20	174	156	-10.34
Other	-	-	-	-	-	-	-	-	-
Multi-racial	6	7	16.67	-	5	-	6	6	0.00
Gender									
Female	128	103	-19.53	74	66	-10.81	87	65	-25.29
Male	229	285	24.45	162	236	45.68	207	225	8.70

Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information. Data Source: Electronic Death Registry System

OPIOID OVERDOSE MORTALITY BY HOUR AND DAY AMONG CLARK COUNTY RESIDENTS, 2023



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

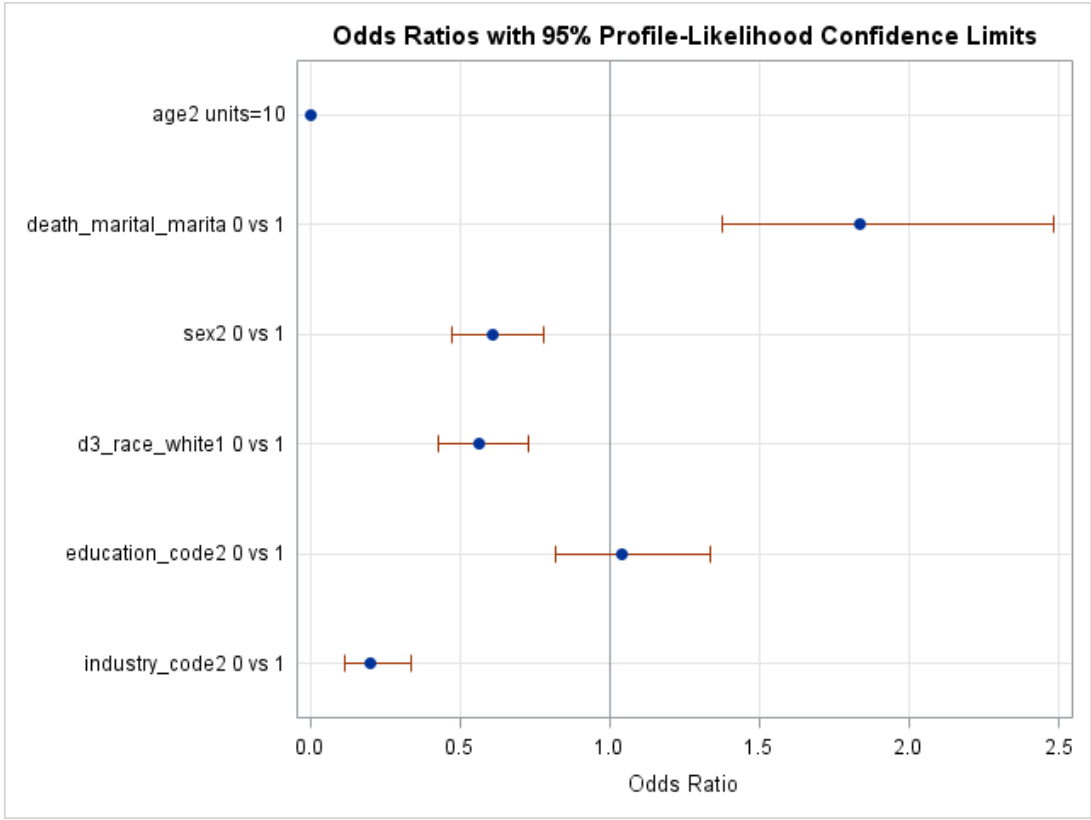
Data Source: Electronic Death Registry System

Adjusted Odds Ratio Estimates for Fatal Opioid Overdose, 2023

Odds Ratio Estimates for Fatal Overdose

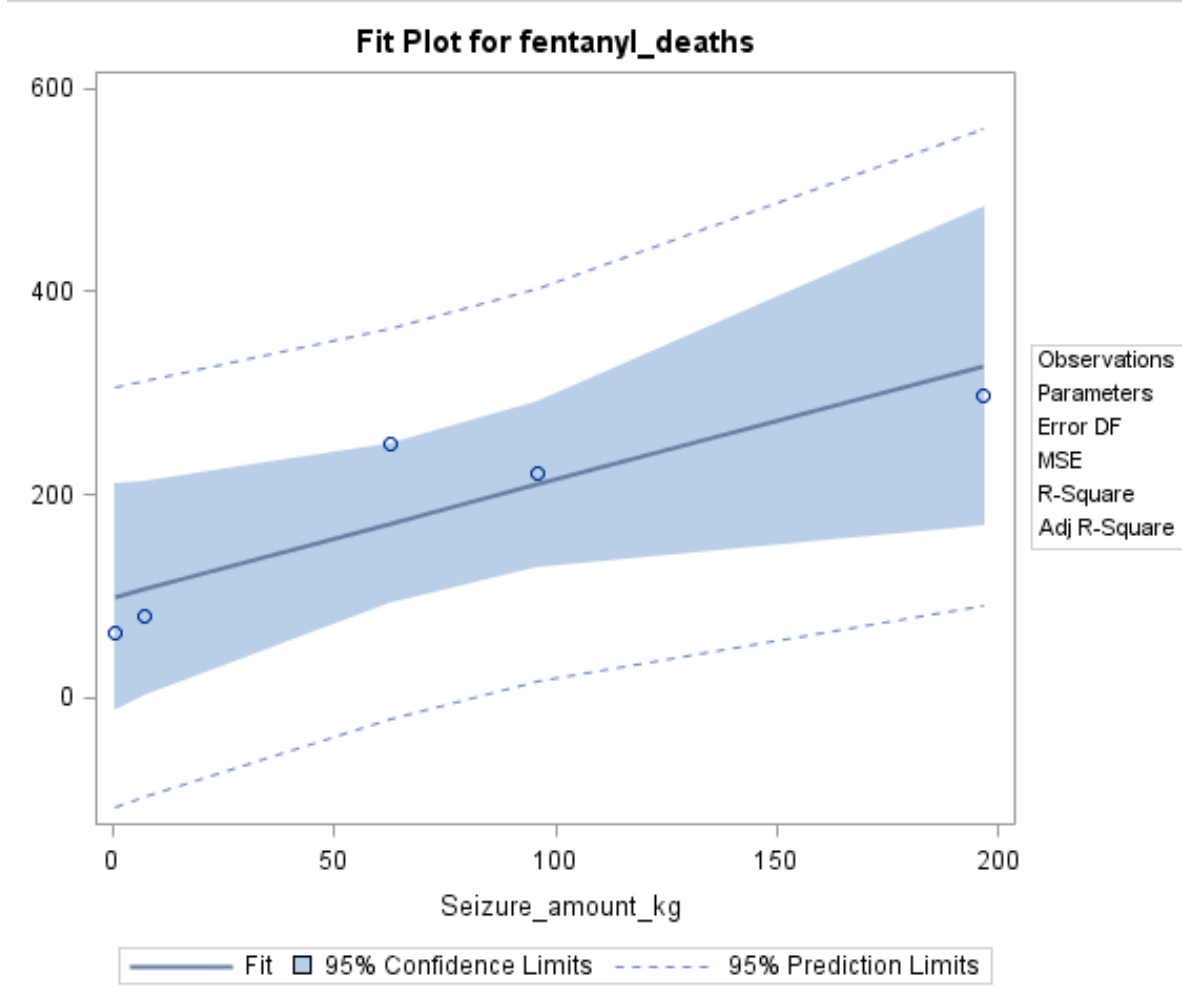
Covariate	N	Odds Ratio	95% Confidence Limits		P Value
Age (unit=10 years)	17,530	<0.00	<0.00		<.0001**
		1	1	<0.001	*
Sex					
Male	9,853	(Ref)	(Ref)	(Ref)	(Ref)
Female	8,051	0.609	0.475	0.777	<.0001**
					*
Employment Status					
Employed	17,083	(Ref)	(Ref)	(Ref)	(Ref)
Not Employed	823	0.202	0.114	0.336	<.0001**
					*
Race					
White	13,512	(Ref)	(Ref)	(Ref)	(Ref)
Non-White	4,394	0.562	0.427	0.73	<.0001**
					*
Marital Status					
Married	6,427	(Ref)	(Ref)	(Ref)	(Ref)
Not Married	11,479	1.835	1.376	2.482	<.0001**
					*
Education					
High School Graduate, GED, or Less School	10,255	1.043	0.819	1.335	.7327
Some College or College Degree (e.g., Associates, Bachelors)	7,651	(Ref)	(Ref)	(Ref)	(Ref)

The estimate for the age variable contains the odds ratio for every change of 10 years.
The White race variable includes both Hispanic White and non-Hispanic White
*p<.05, ** p<.01, *** p<.001



Data Source: Electronic Death Registry System

Linear Regression of Overdose Deaths Involving Fentanyl Among Clark County Residents and Fentanyl Seizures, 2018-2022



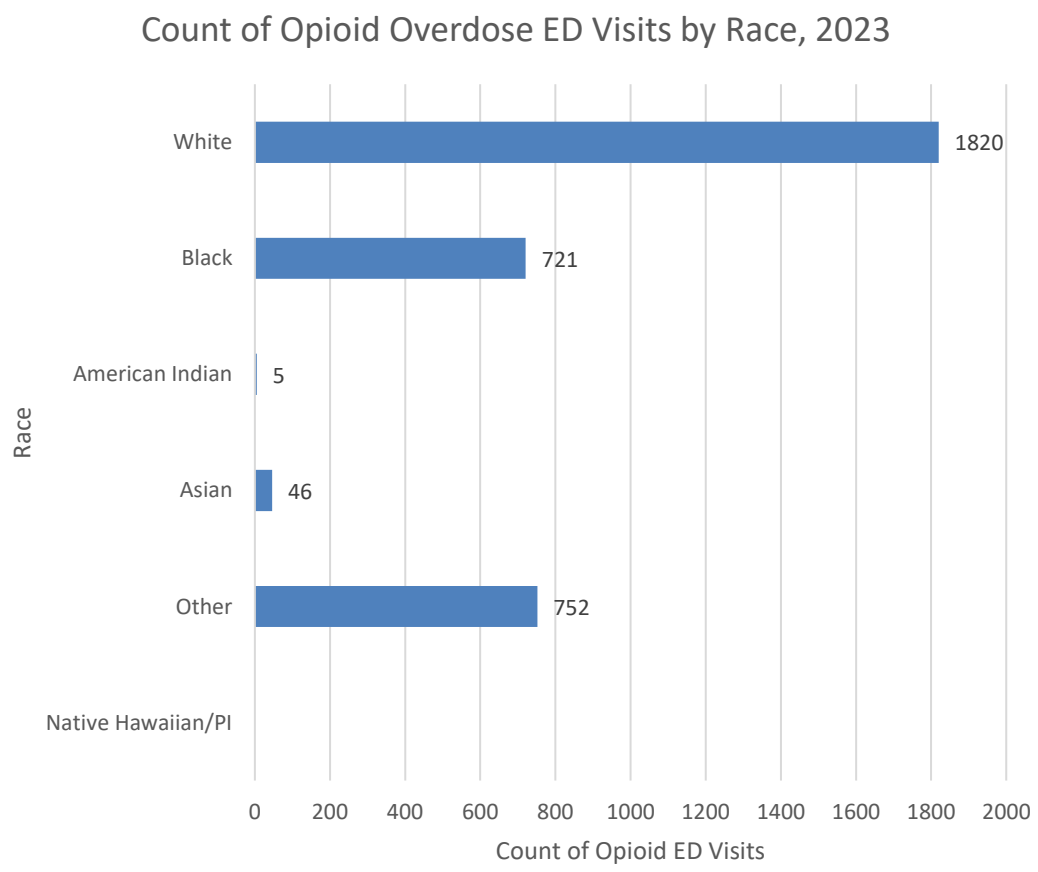
Analysis of Variance					
Source	DF	Sum of Square	Mean Square	F Value	Pr > F
Model	1	34341	34341	11.35	0.0434
Error	3	9076.36105	3025.45368		
Corrected Total	4	43417			

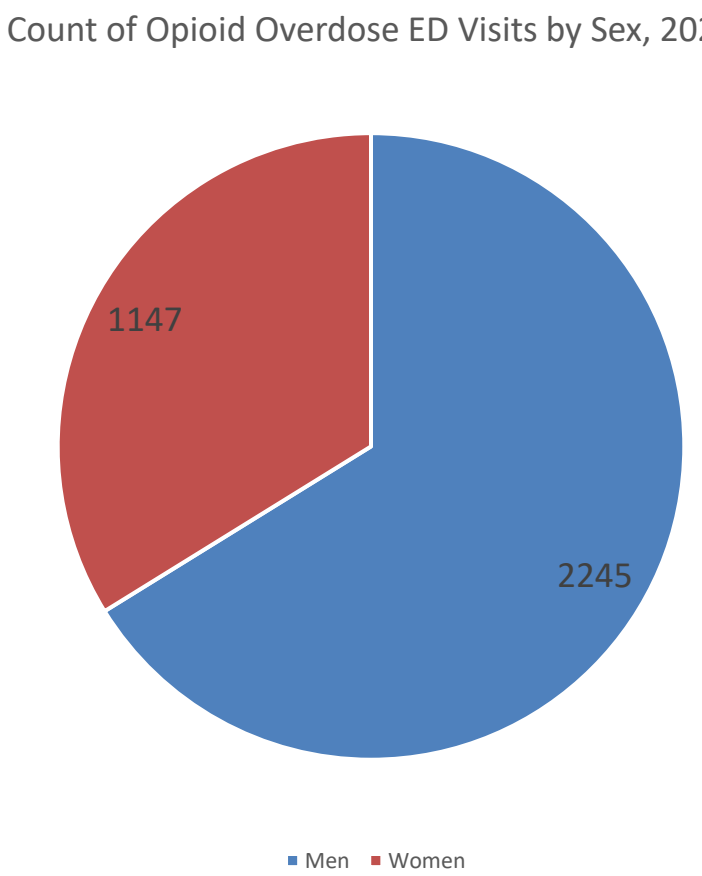
Data Source: Electronic Death Registry System; HIDTA Seizures

SECTION II: NON-FATAL INDICATORS

- ESSENCE (Syndromic Surveillance)
- ESO

Opioid Overdose ED Visit Descriptive Statistics Using ESSENCE Among Clark County Residents & Non-Residents, 2023

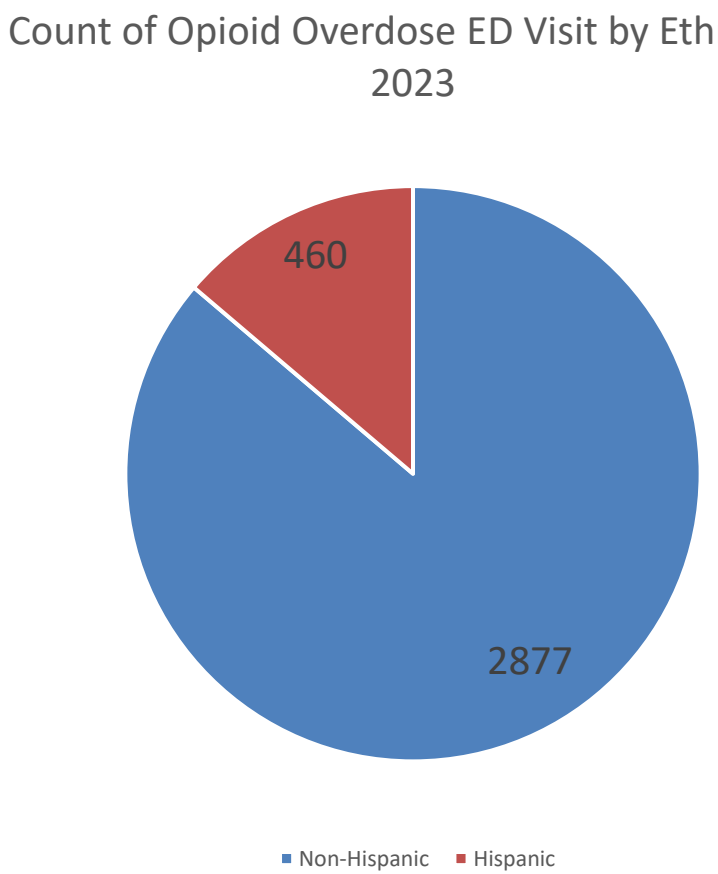


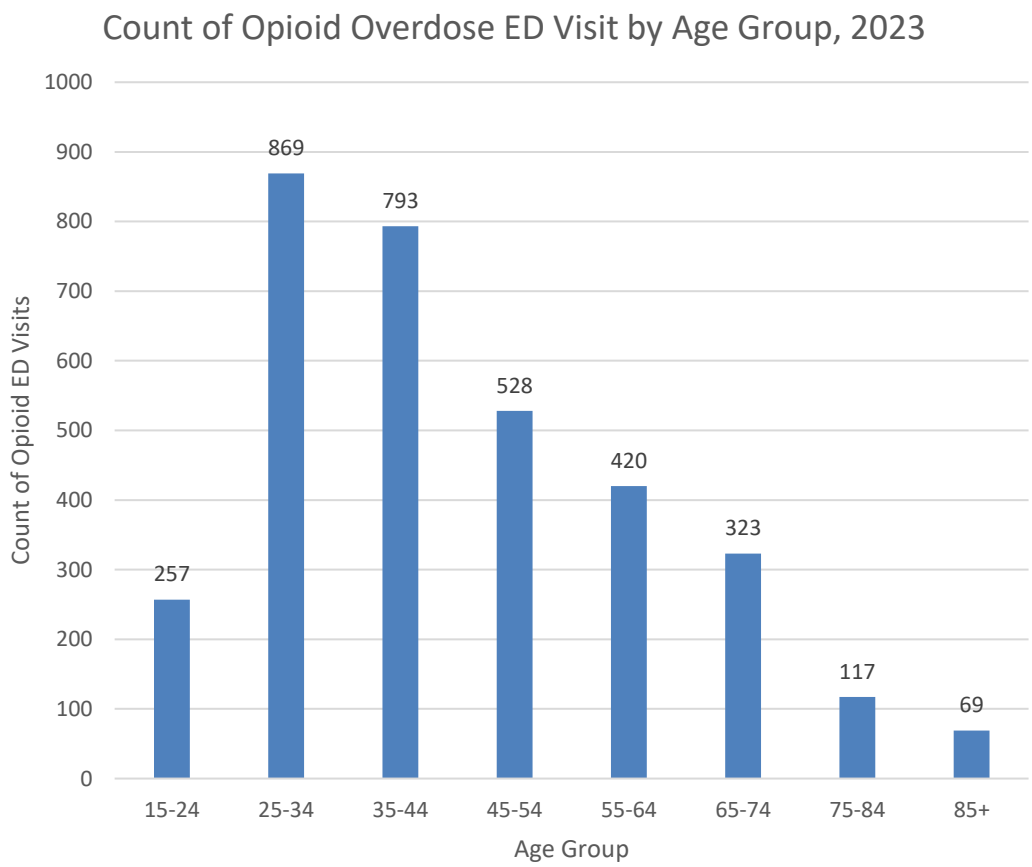


Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: ESSENCE

Opioid Overdose ED Visit Descriptive Statistics Using ESSENCE Among Clark County Residents & Non-Residents, 2023 (Cont.)

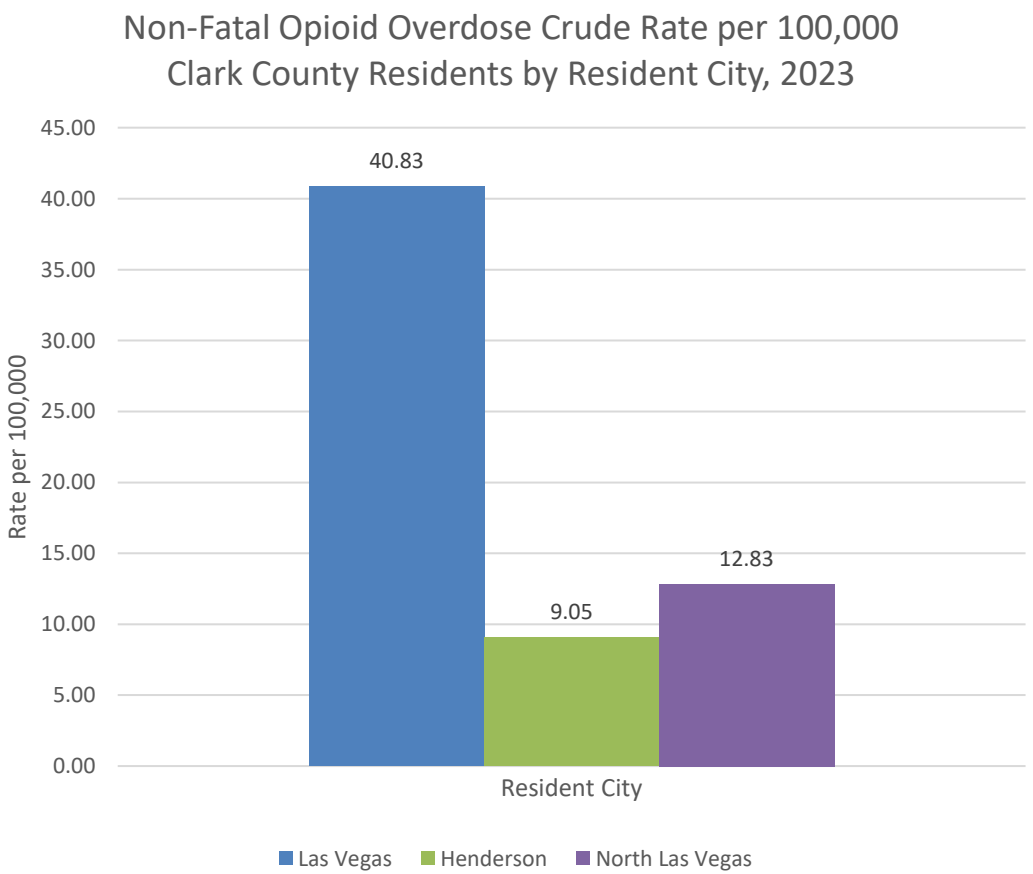


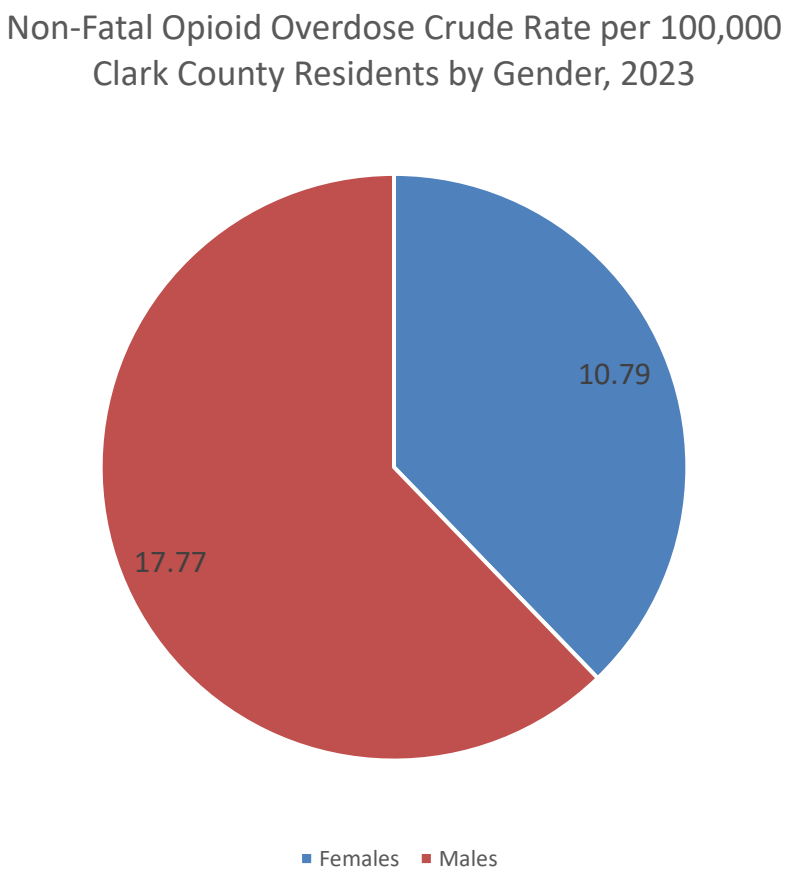


Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: ESSENCE

Non-Fatal Opioid Overdose Descriptive Statistics Using ESO Among Clark County Residents, 2023

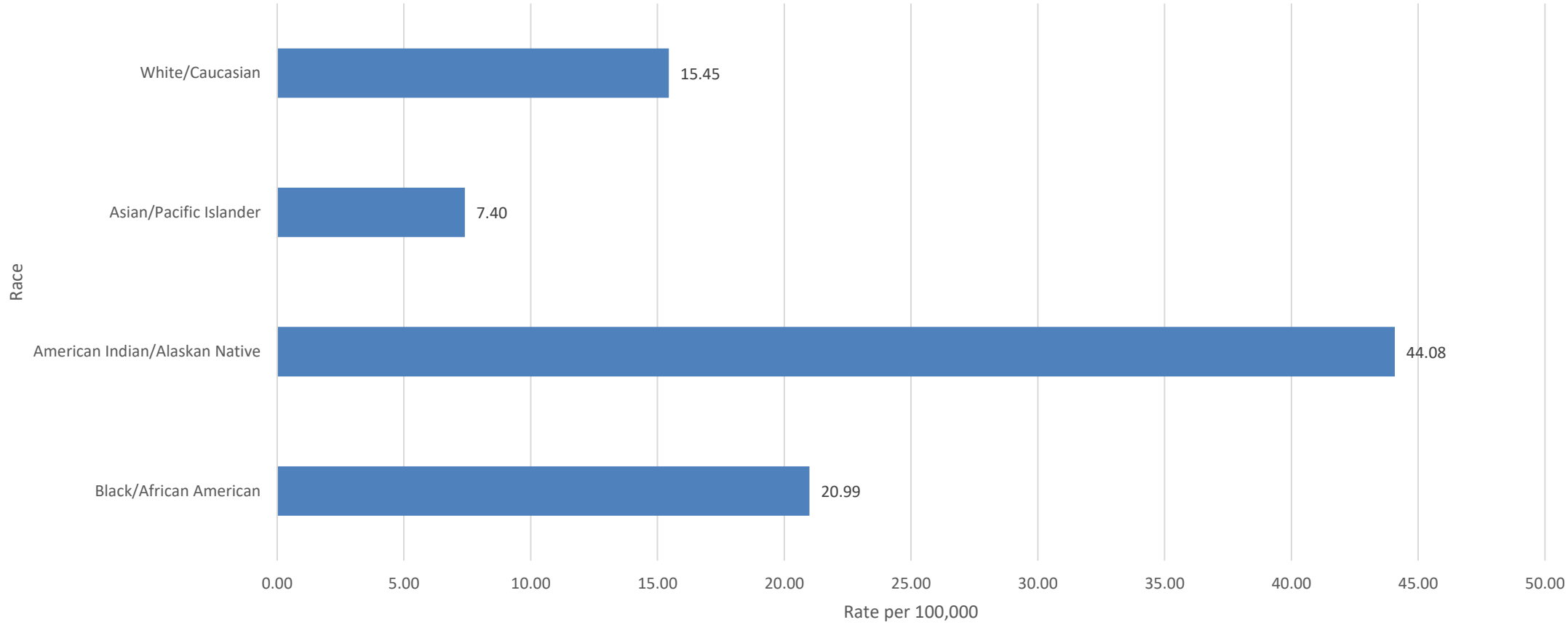




Note: Rates with a numerator less than 12 have been suppressed for reliability.

Data Source: ESO

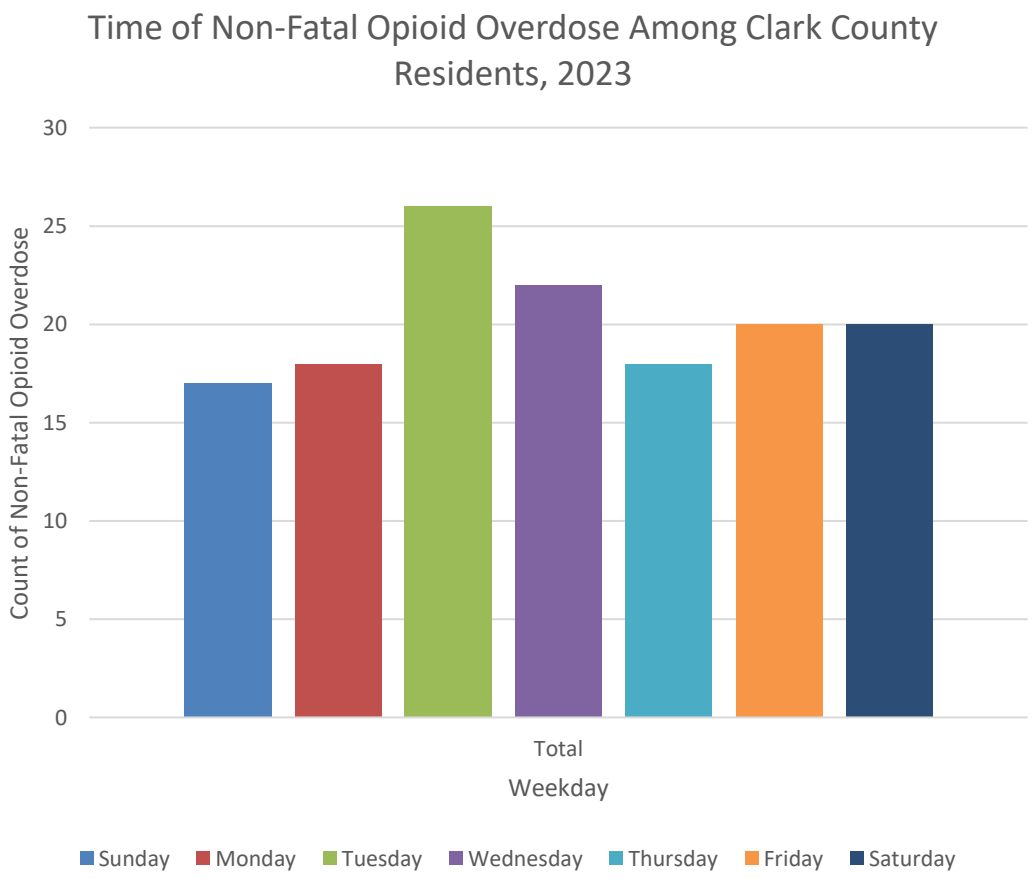
Non-Fatal Opioid Overdose Descriptive Statistics Using ESO Among Clark County Residents, 2023 (Cont.)

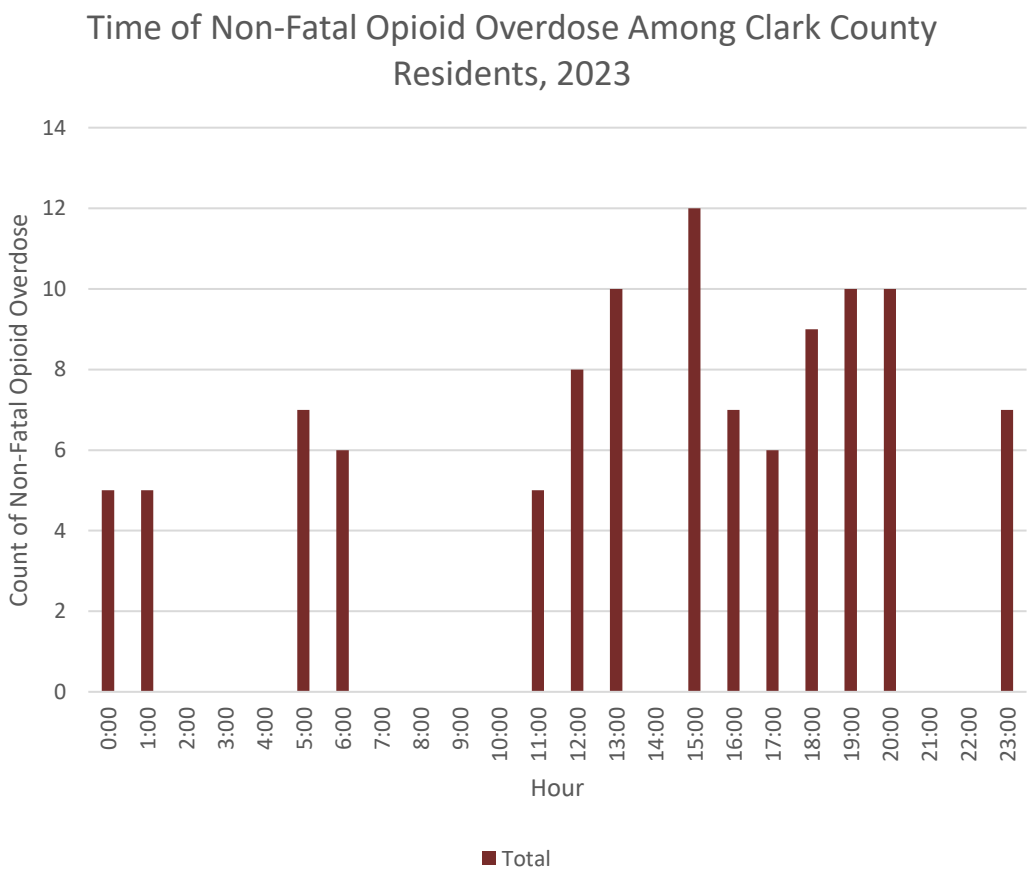


Note: Rates with a numerator less than 12 have been suppressed for reliability.

Data Source: ESO

Non-Fatal Opioid Overdose by Hour and Day Using ESO Among Clark County Residents & Non-Residents, 2023

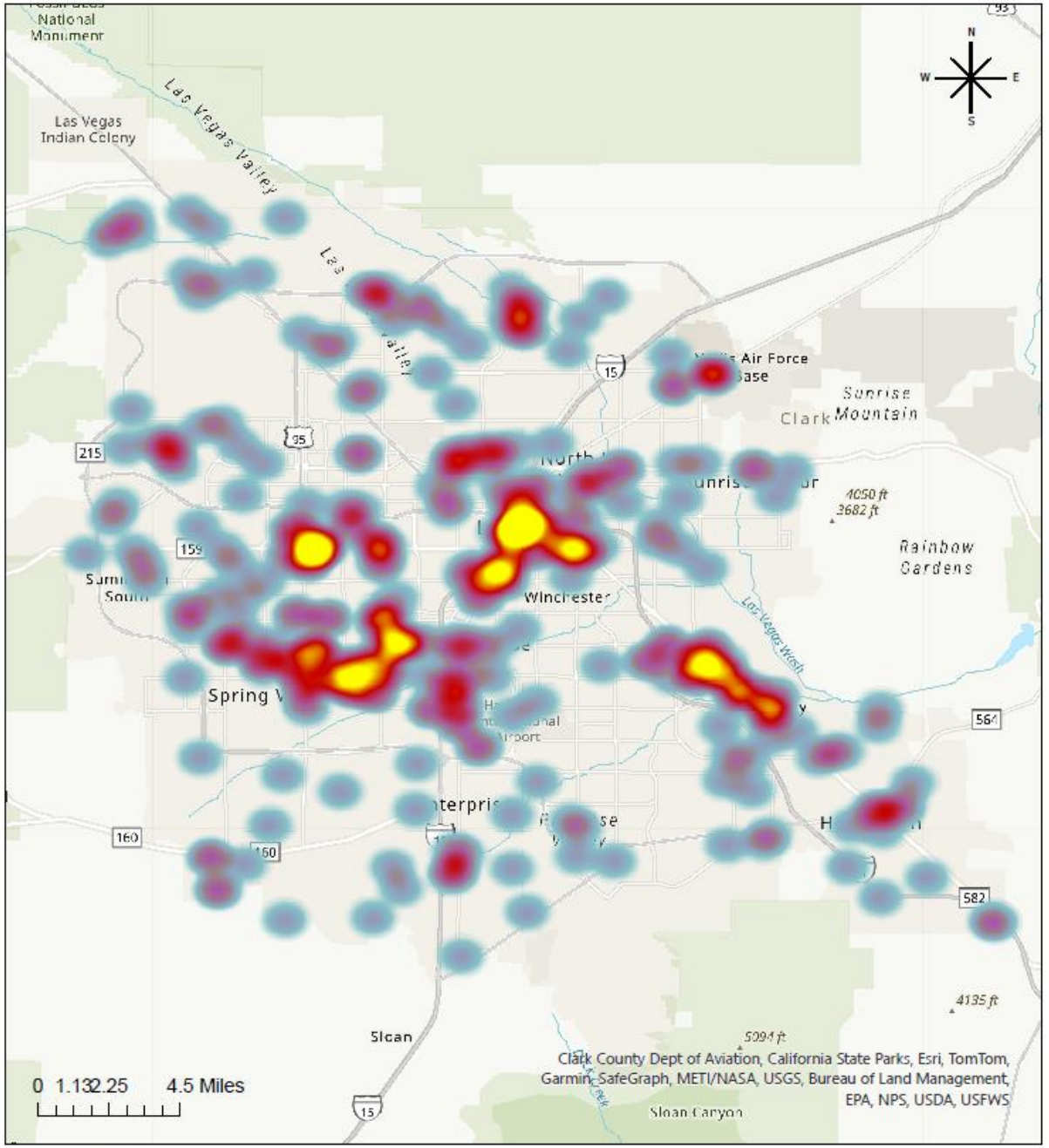




Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: ESO

NON-FATAL OPIOID OVERDOSE HEAT MAP USING INJURY LOCATION AMONG CLARK COUNTY RESIDENTS & NON-RESIDENTS, 2023



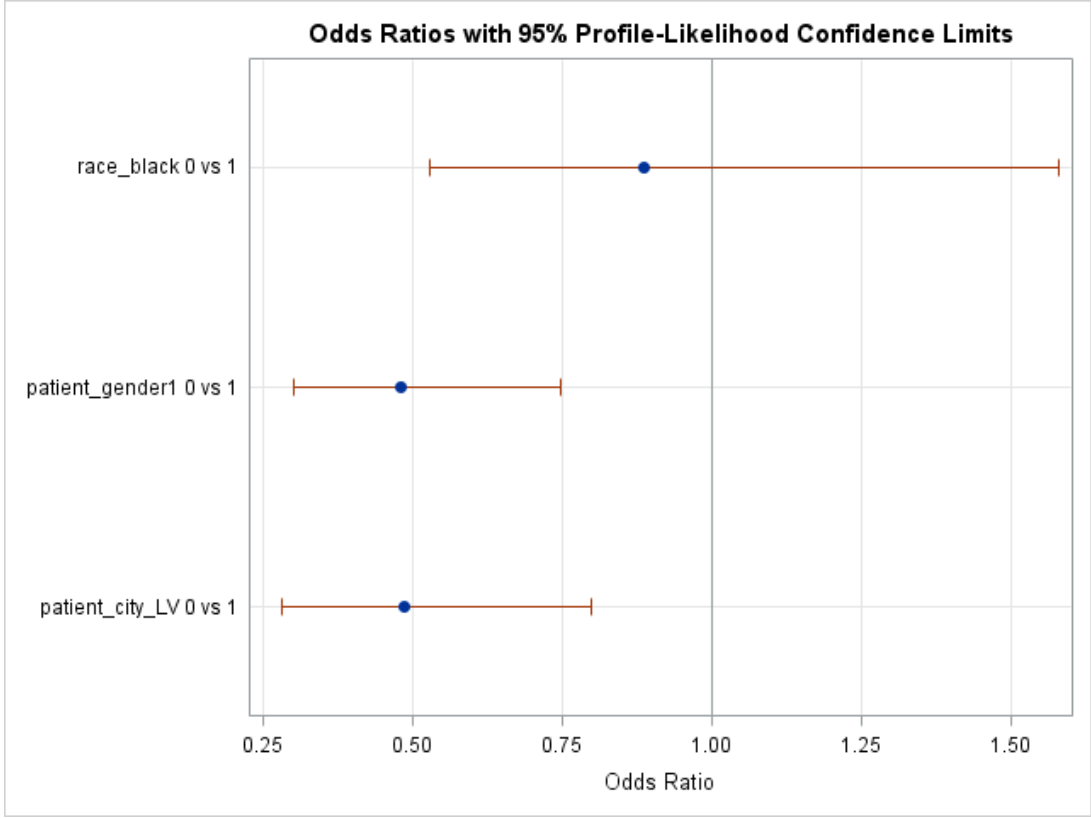
Clusters are located Downtown, Rainbow & Charleston, Naked City, and Boulder Highway.

Data Source: ESO

Adjusted Odds Ratio Estimates for Non-Fatal Opioid Overdose Using ESO Among Clark County Residents & Non-Residents, 2023

Odds Ratio Estimates for Non-Fatal Opioid Overdose

Covariate	N	Odds Ratio	95% Confidence Limits		P Value
Sex					
Male	14,760	(Ref)	(Ref)	(Ref)	(Ref)
Female	14,574	0.386	0.228	0.629	0.0011
Race					
Black	24,241	(Ref)	(Ref)	(Ref)	(Ref)
Non-Black	5,148	0.830	0.484	1.516	0.5183
Patient City LV					
Resided in Las Vegas	19,525	(Ref)	(Ref)	(Ref)	(Ref)
Does not reside in Las Vegas	9,864	0.491	0.269	0.841	0.0137

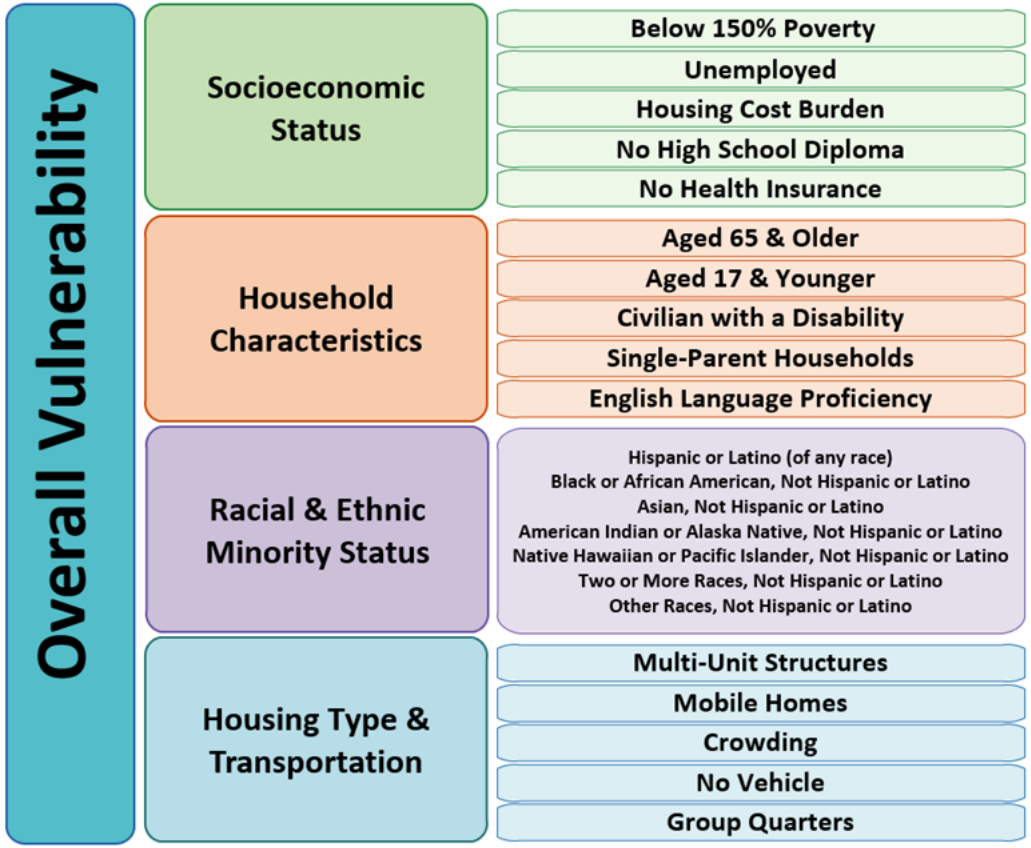


Data Source: ESO

SECTION III: SOCIAL VULNERABILITY INDEX INDICATORS

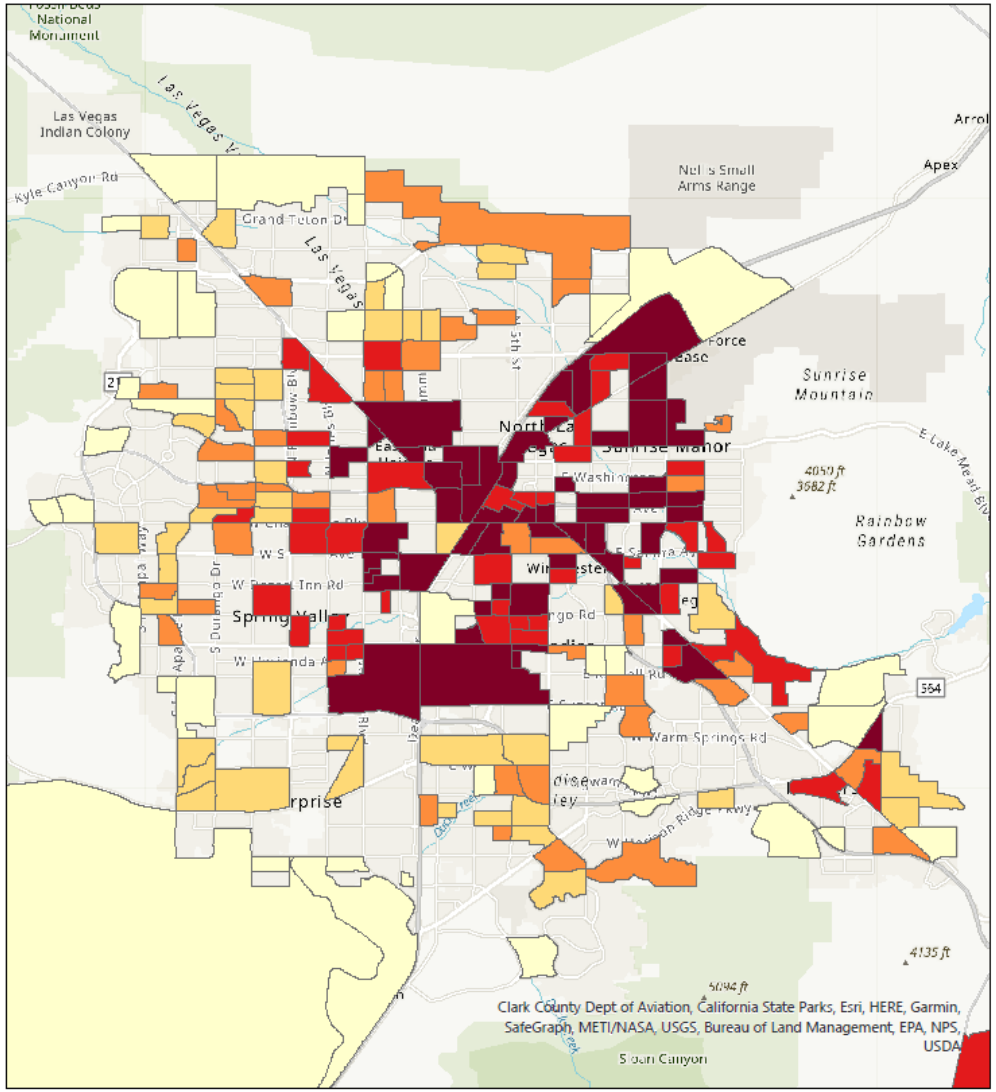
- Electronic Death Registry System
- Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index

Social Vulnerability Index (SVI)



Source: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

LAS VEGAS MAP WITH OVERALL SVI RANKING (GRADUATED COLORS IN CENSUS TRACTS CORRESPONDING TO OVERALL SVI RANKING), 2020



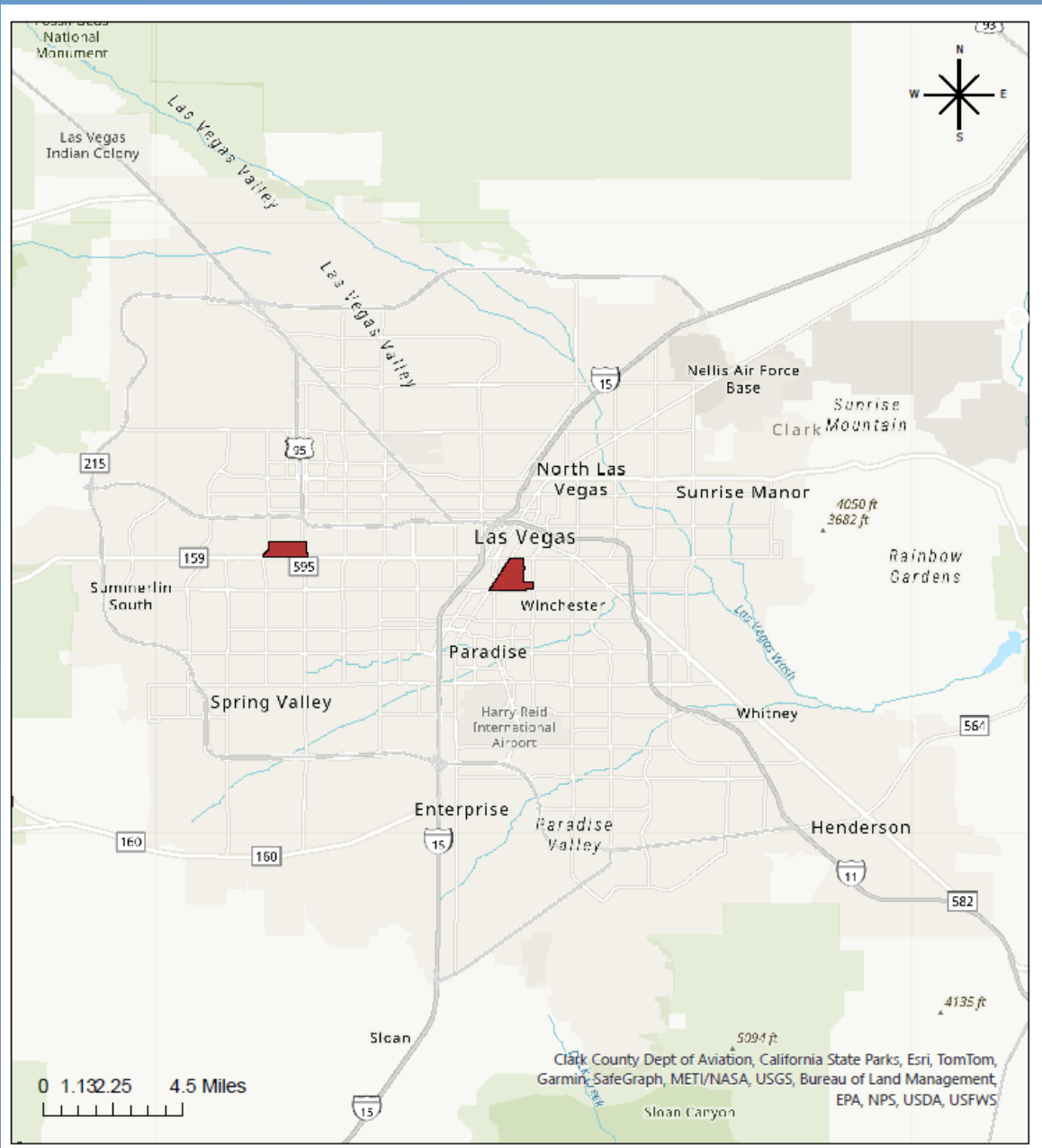
SVI Ranking

RPL_THEMES

- ≤0.258800
- ≤0.488900
- ≤0.689200
- ≤0.855700
- ≤1.000000
- Clark_County_ZCTA_2015

Data Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index

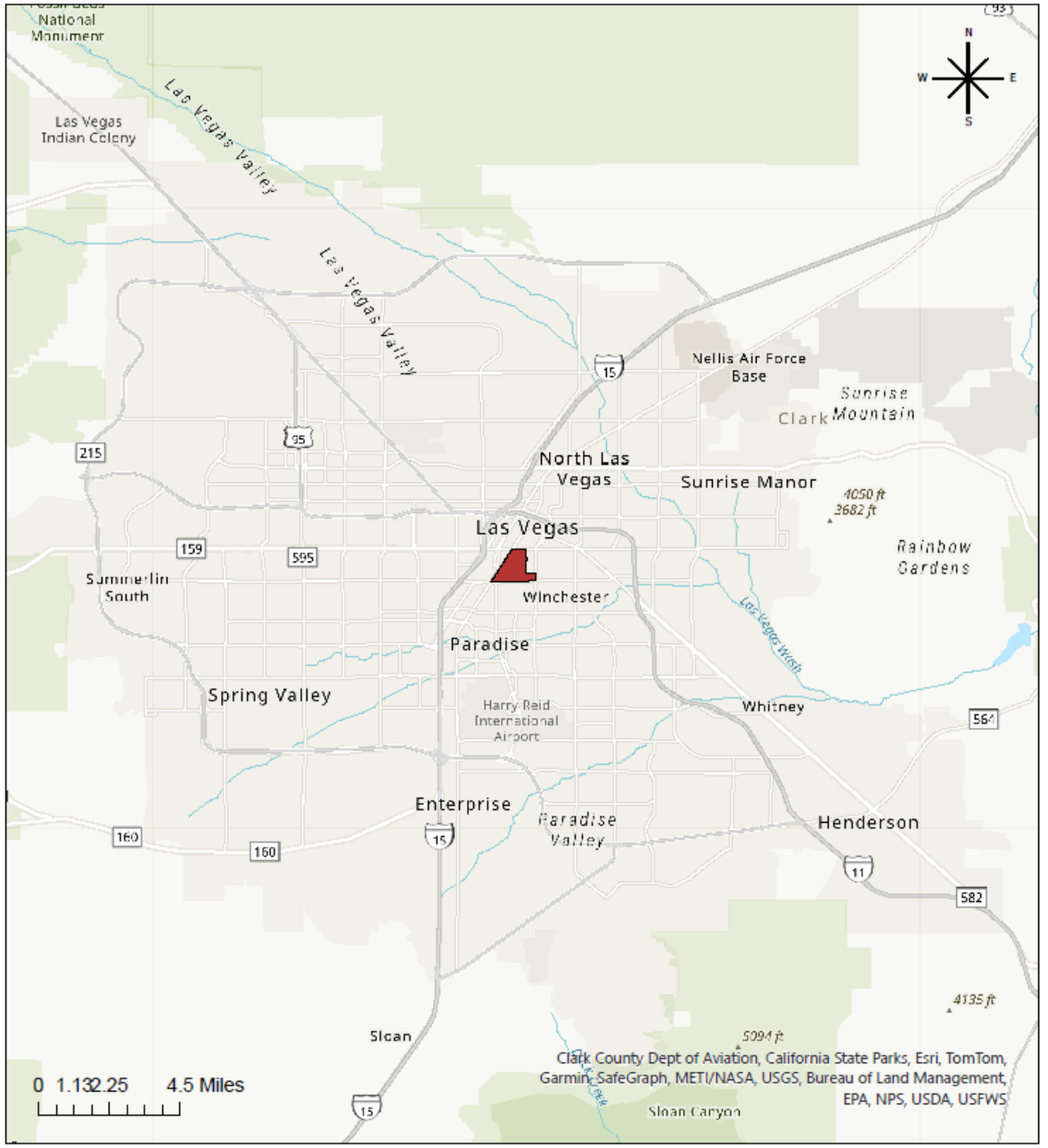
LAS VEGAS MAP WITH OPIOID OVERDOSE DEATH COUNTS AMONG CLARK COUNTY RESIDENTS (GRADUATED COLORS IN CENSUS TRACTS CORRESPONDING TO OVERDOSE COUNTS), 2023



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: Electronic Death Registry System

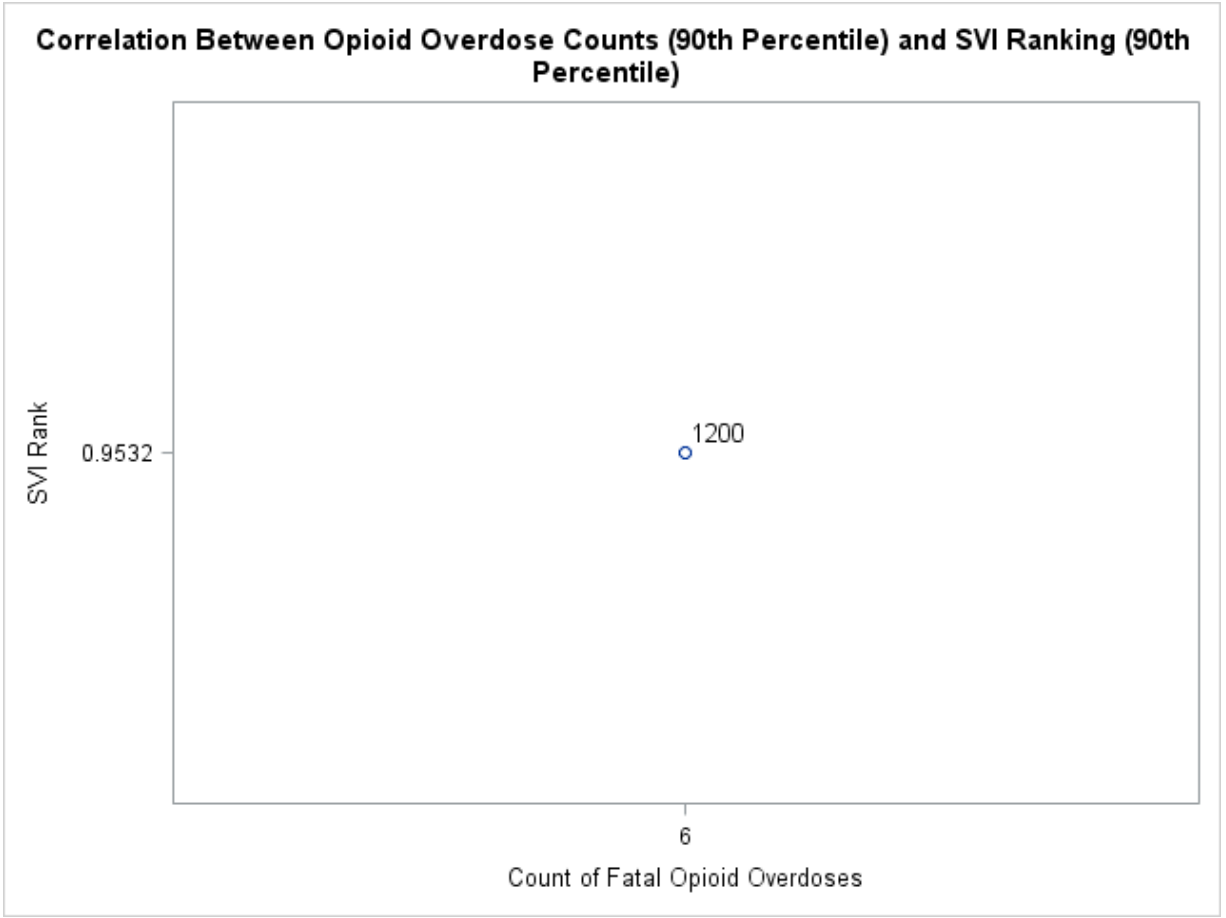
LAS VEGAS MAP WITH OPIOID OVERDOSE COUNTS (90TH PERCENTILE) AND OVERALL SVI RANKING (90TH PERCENTILE) AMONG CLARK COUNTY RESIDENTS (GRADUATED COLORS IN CENSUS TRACTS CORRESPONDING TO SVI RANKING), 2023



Note: 90th percentile is where overdose counts>=**3** and SVI >=**.92**. Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index; Electronic Death Registry System

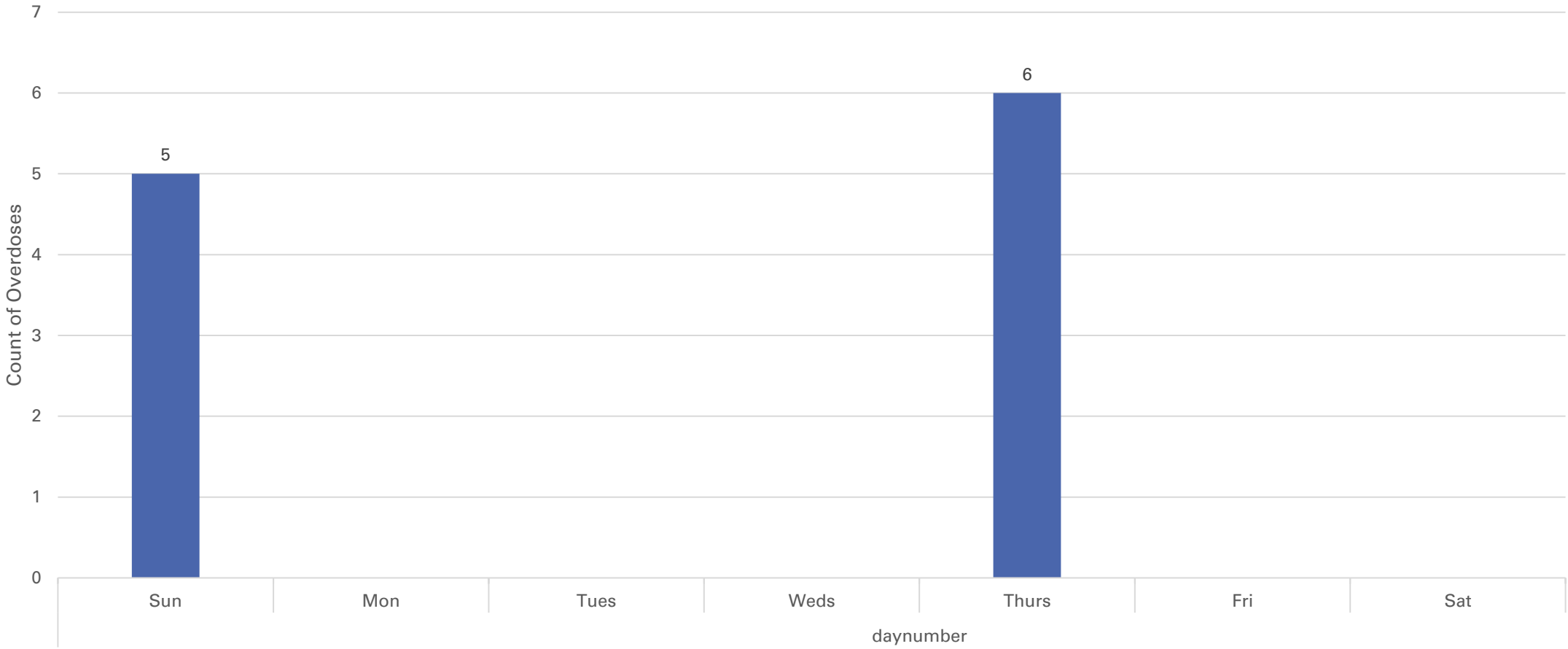
Correlation Between Opioid Overdose Counts (90th Percentile) and Overall SVI Ranking (90th Percentile) by Census Tract, 2023



Note: 90th percentile is where overdose counts>=**3** and SVI >=**.92**. Data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index; Electronic Death Registry System

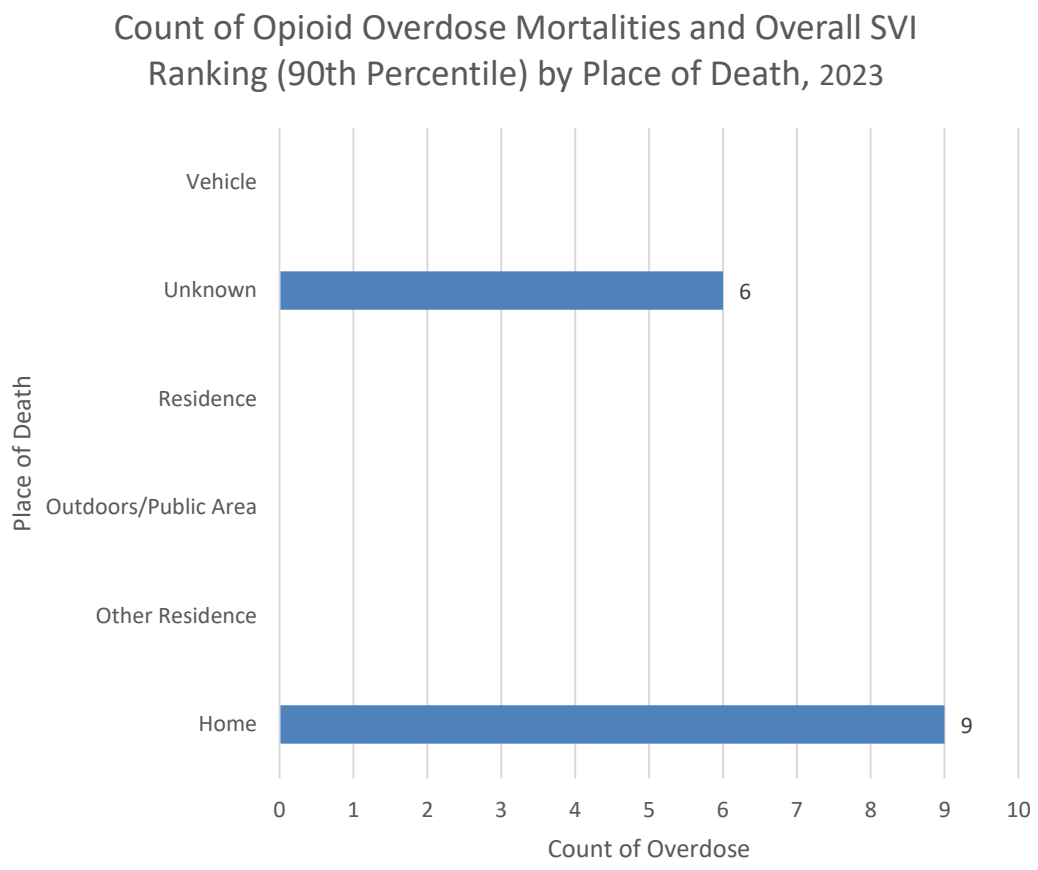
Opioid Overdose Mortality (90th Percentile) and Overall SVI Ranking (90th Percentile) by Day, 2023

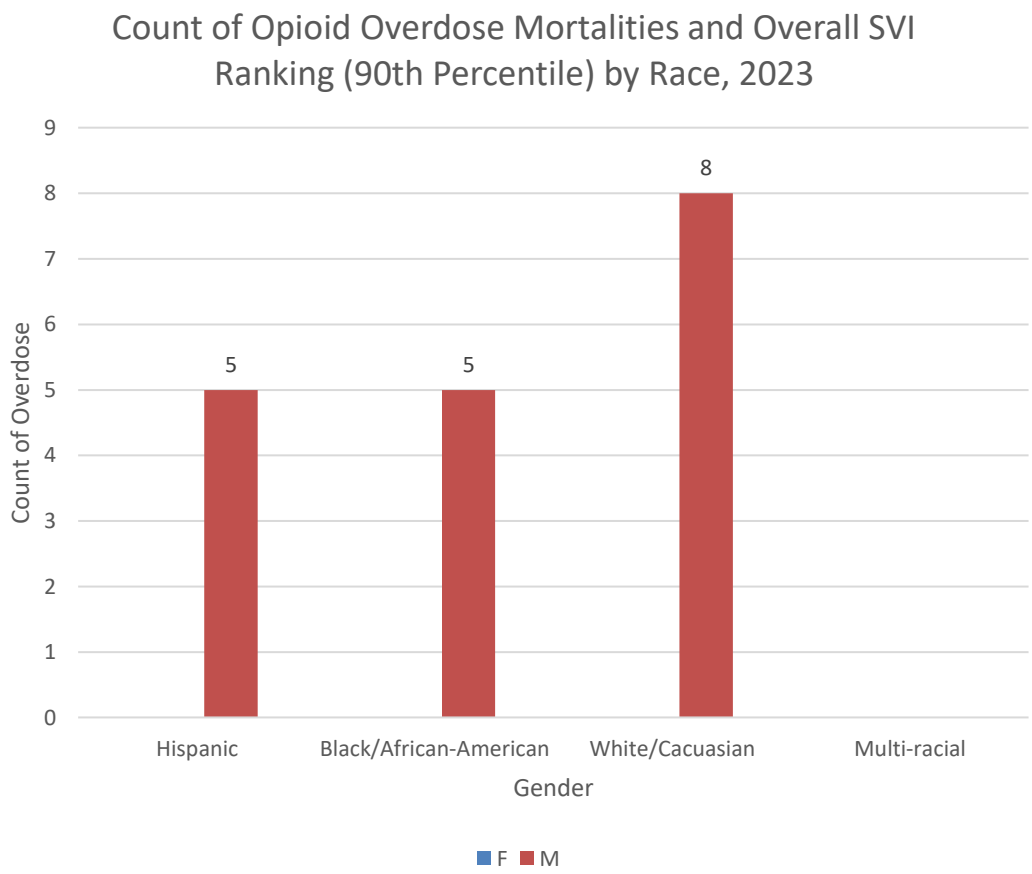


Note: 90th percentile is where overdose counts>=3 and SVI >=.92. Data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index; Electronic Death Registry System

90th Percentile Descriptive Statistics: Opioid Overdose Mortality and Overall SVI Ranking, 2023

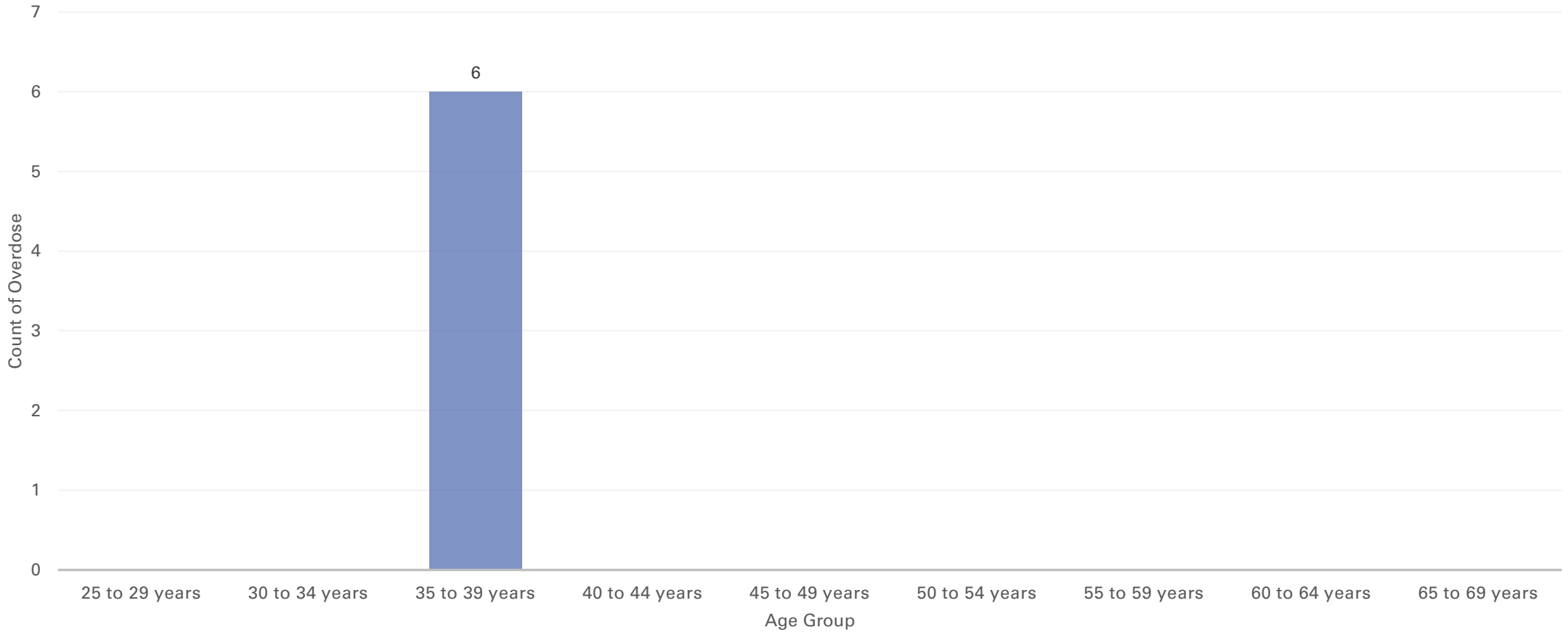




Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index; Electronic Death Registry System

90th Percentile Descriptive Statistics: Opioid Overdose Mortality and Overall SVI Ranking, 2023 (Cont.)



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

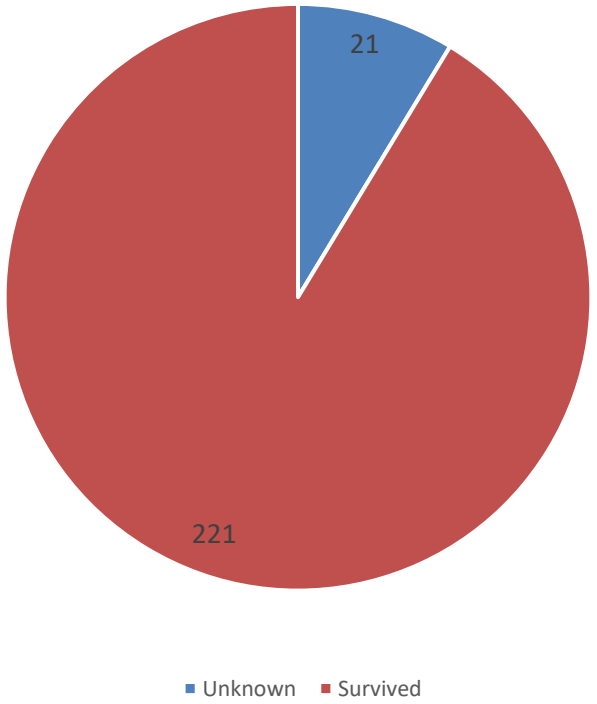
Data Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index; Electronic Death Registry System

SECTION IV: NALOXONE INDICATORS

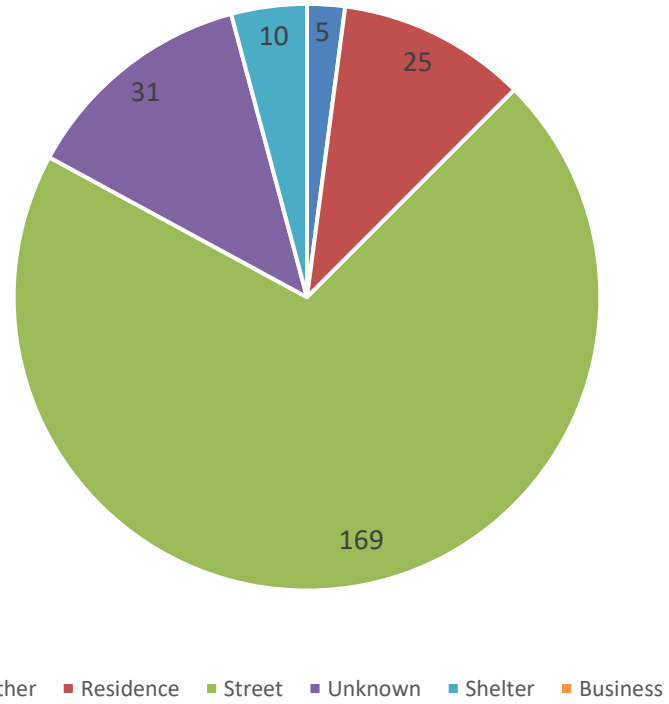
- L2A Naloxone Administration Surveys
- FR-CARA Post-Administration Surveys
- FR-CARA Naloxone Distribution Log

Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through SNHD's Linkage to Action (L2A) Team, 09/2022- 04/2023

L2A: The Outcome of the Individual Receiving Naloxone, 09/2022-04/2023



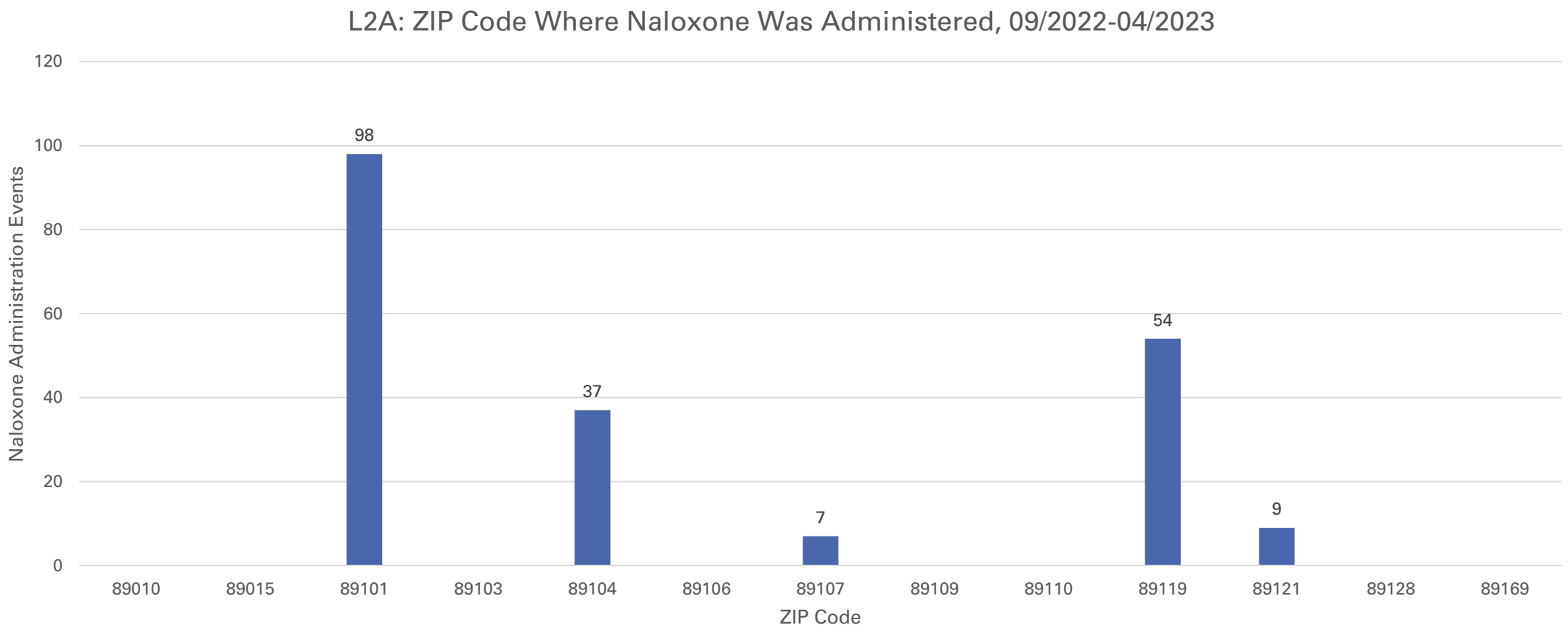
L2A: The Location Type Where the Naloxone Administration Occurred, 09/2022-04/2023



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: L2A Naloxone Administration Surveys.

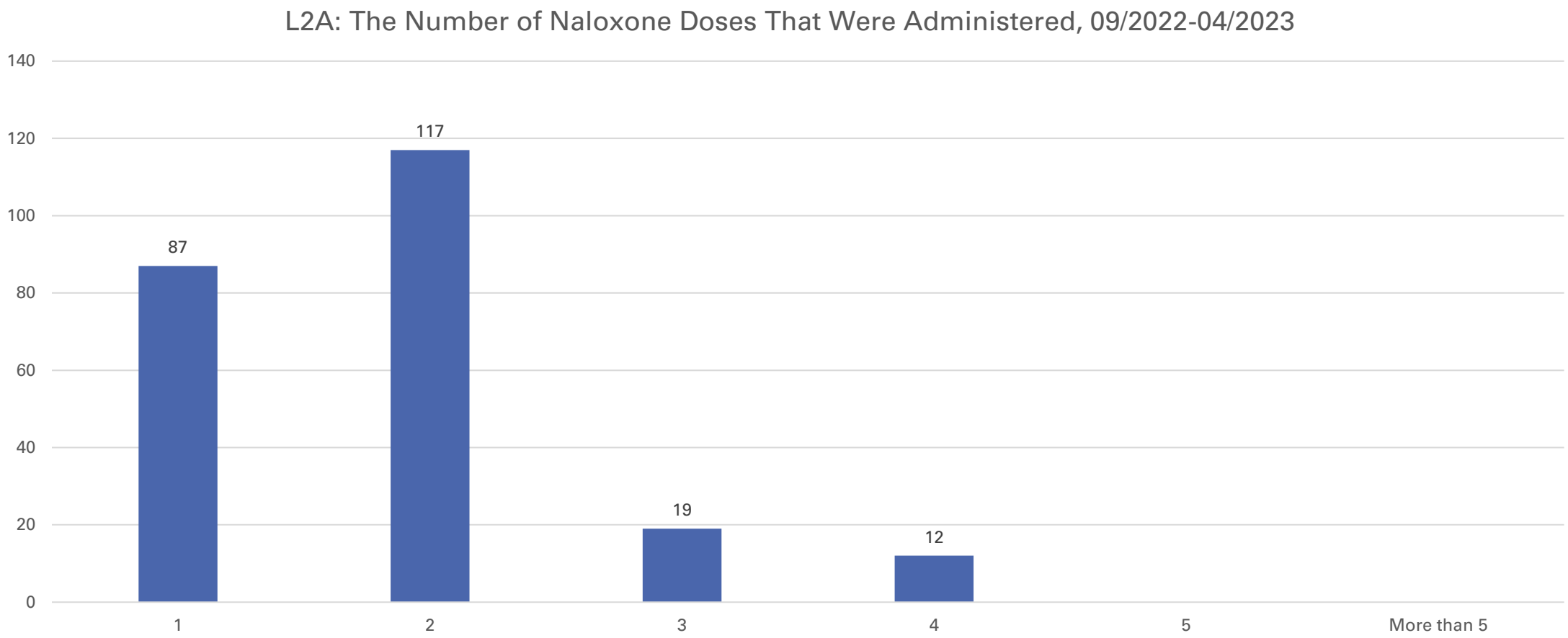
Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through SNHD's Linkage to Action (L2A) Team, 09/2022- 04/2023 (Cont.)



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: L2A Naloxone Administration Surveys.

Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through SNHD's Linkage to Action (L2A) Team, 09/2022- 04/2023 (Cont.)

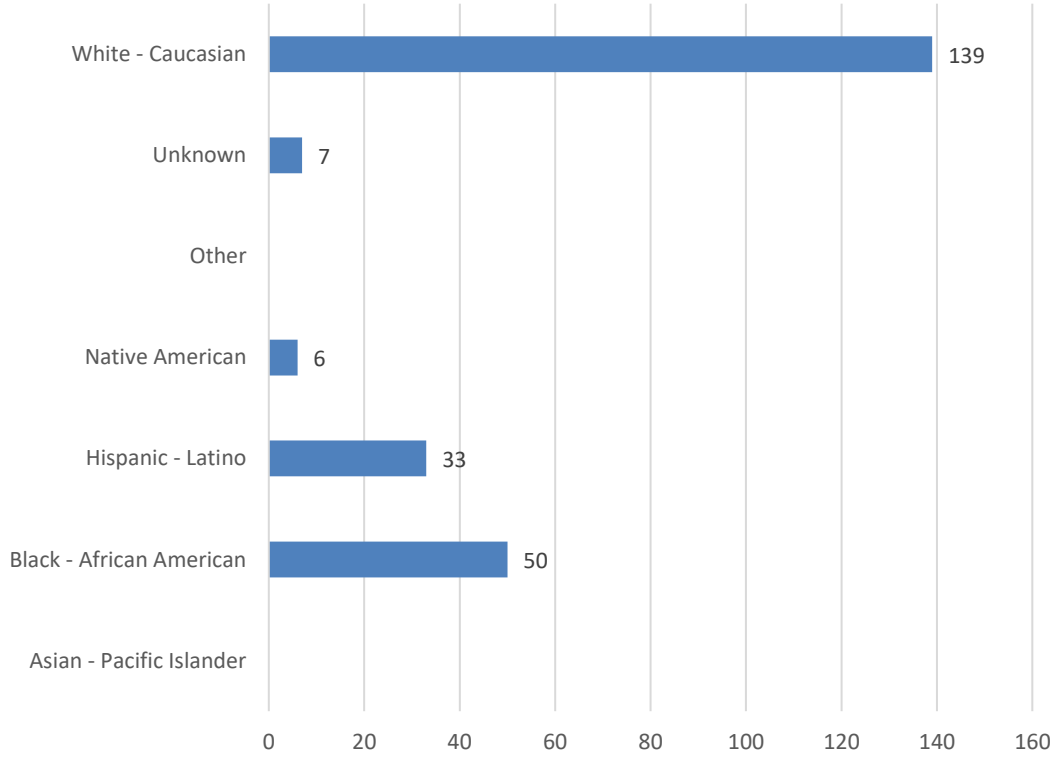


Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

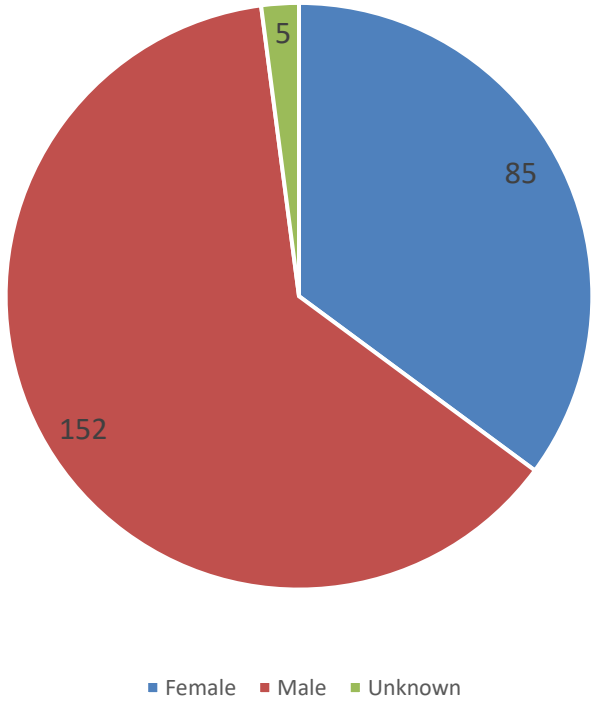
Data Source: L2A Naloxone Administration Surveys.

Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through SNHD's Linkage to Action (L2A) Team, 09/2022- 04/2023 (Cont.)

L2A: The Race/Ethnicity of the Individual Who Received the Naloxone Administration, 09/2022-04/2023



L2A: The Gender of the Individual Who Received the Naloxone Administration, 09/2022-04/2023

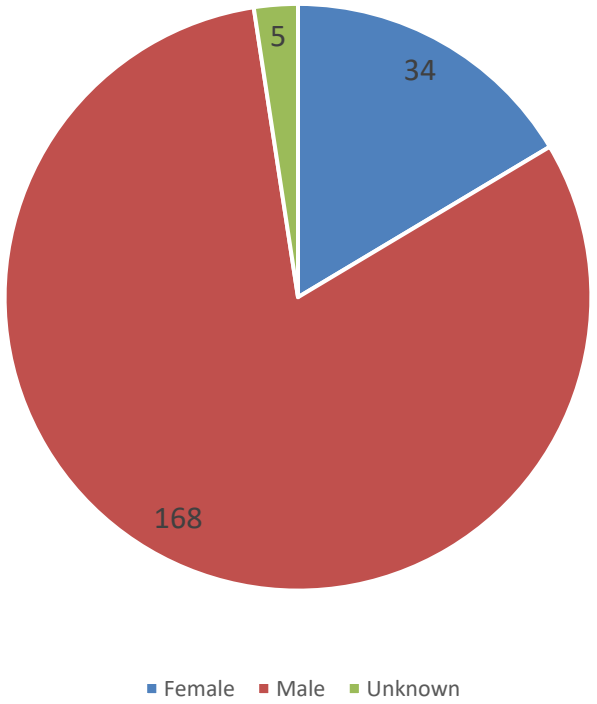


Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

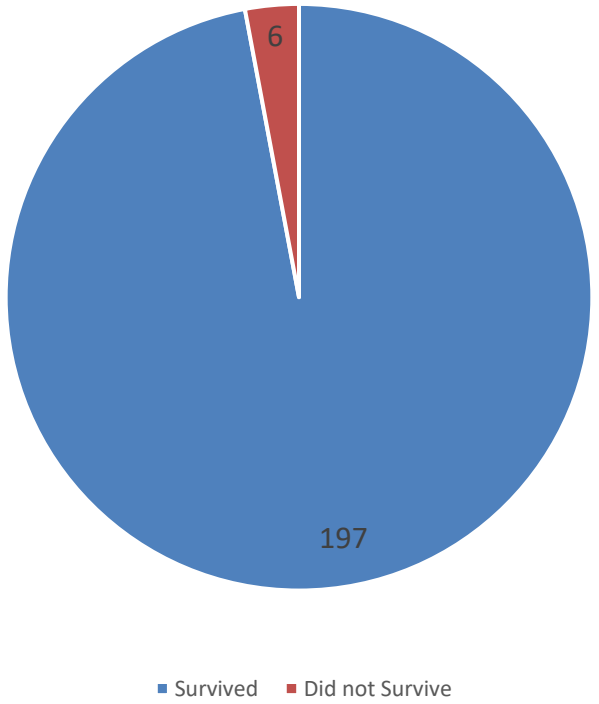
Data Source: L2A Naloxone Administration Surveys.

Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through FR-CARA and SOR Funds, 2019-2024

The Gender of the Individual who Received the Naloxone Administration, 2019-2024



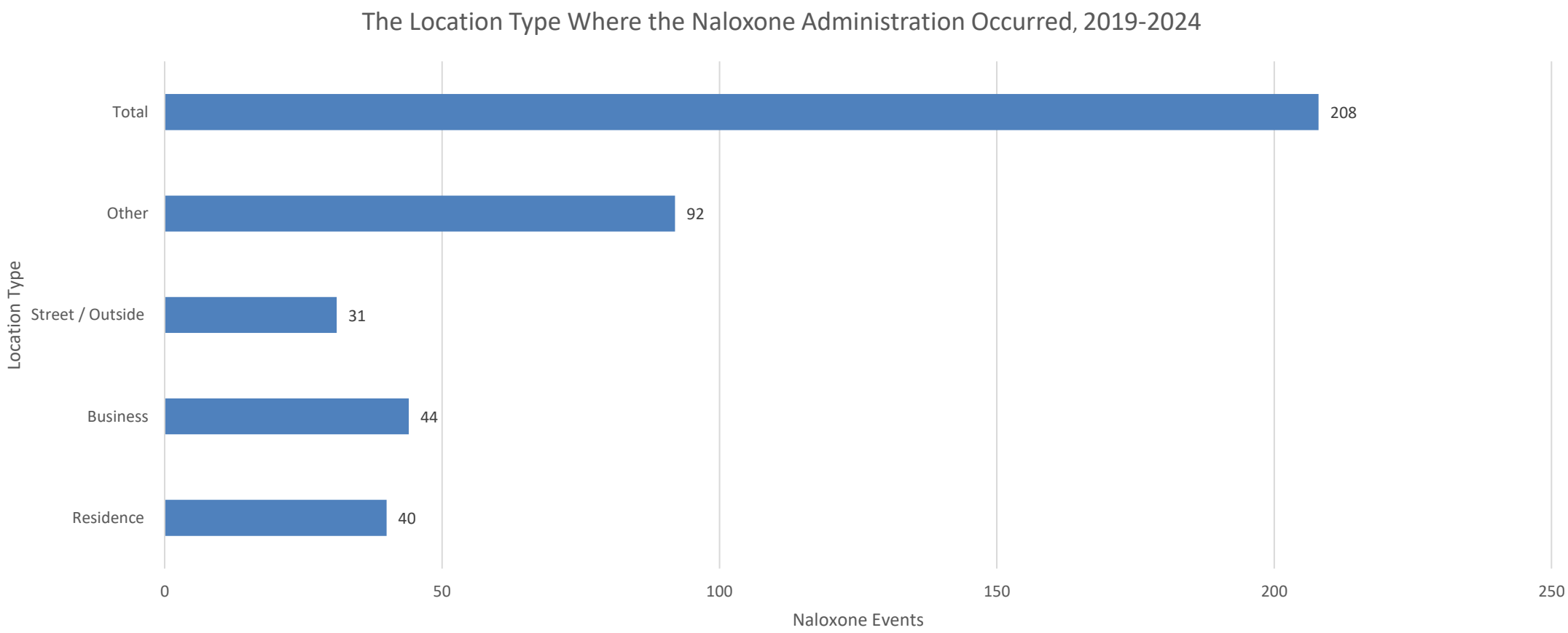
The Outcome of the Individual Receiving Naloxone, 2019-2024



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: FR-CARA Post Administration Surveys.

Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through FR-CARA and SOR Funds, 2019-2024 (Cont.)

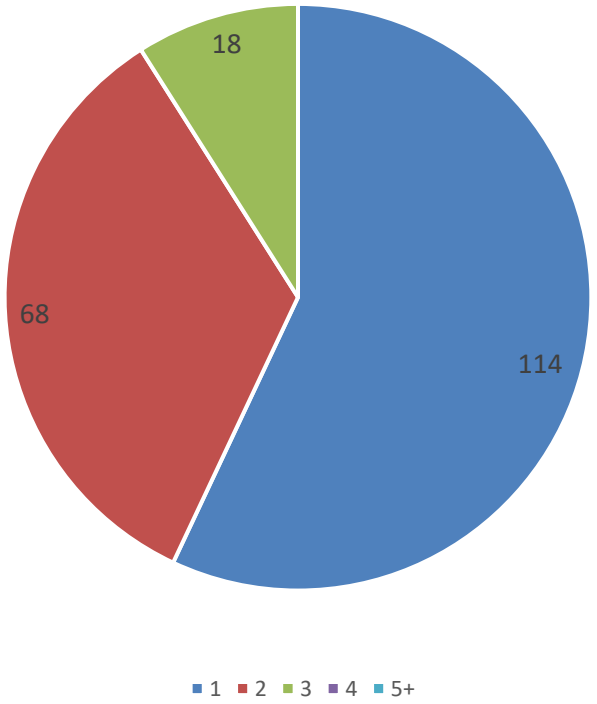


Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

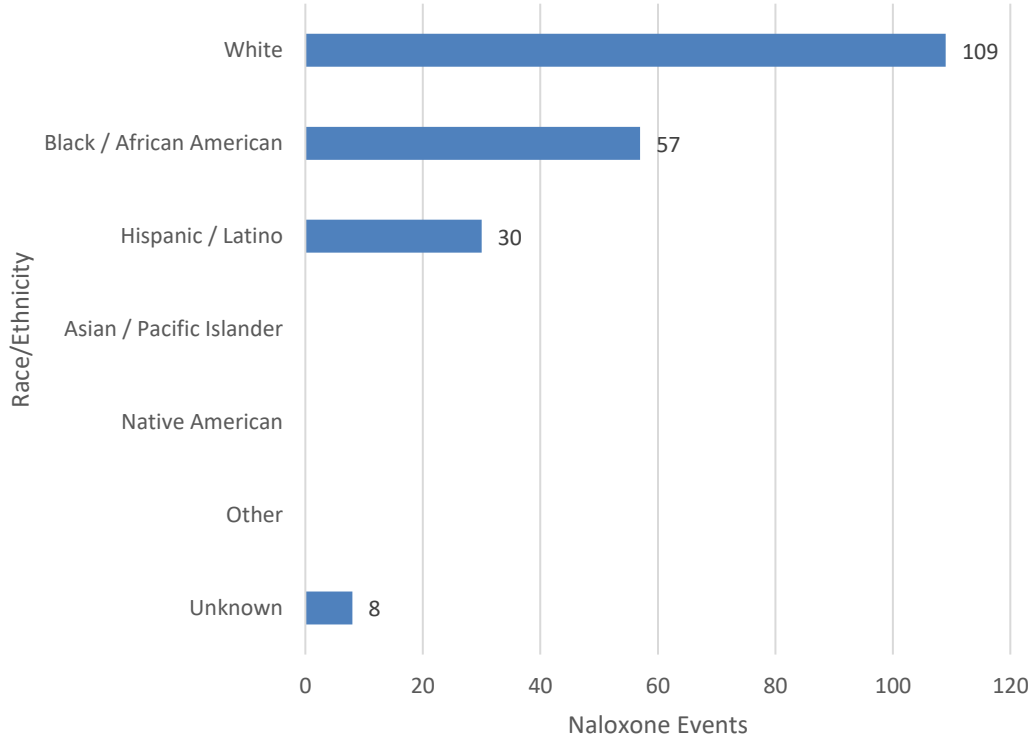
Data Source: FR-CARA Post Administration Surveys.

Descriptive Statistics of Naloxone Administrations from Naloxone Distributed Through FR-CARA and SOR Funds, 2019-2024 (Cont.)

The Number of Naloxone Doses That Were Administered, 2019-2024



The Race/Ethnicity of the Individual Who Received the Naloxone Administration, 2019-2024



Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

Data Source: FR-CARA Post Administration Surveys.

SECTION V: GAPS

Data Gaps/Challenges

- PDMP
- Wastewater
- ODMAP
- Health Disparities
- Comprehensive Substance Use Data
- Timely Data
- Data Suppression

SECTION VI: RECOMMENDATIONS

Recommendations

- Formation of Working Group/Subcommittee

SECTION VII: SUMMARY

Summary: Fatal Data

1. **Demographics:**
    a. Target individuals who are men, employed, White, and not married since these individuals have a higher odds of dying from an opioid overdose in 2023 (Slide 19).
    b. Target men as they have a much higher opioid overdose death rate compared to women in 2023 (Slide 14).
    c. Target individuals who are Black and individuals who are White as these race groups have a much higher opioid overdose death rate compared to other race groups in 2023 (Slide 14).
    d. Target individuals who are 35-39, 30-34, and 45-49 as these are the three age groups with the highest opioid overdose death rates in 2023 (Slide 15).
    e. Target individuals who are White, male, and individuals aged 35-39 as these groups have higher opioid death counts compared to other groups in 2023 when factoring in the Social Vulnerability Index and Opioid Overdose Mortality (90th percentile in each) (Slide 36, Slide 37). Data in Slide 36 and Slide 37 are derived from count data; therefore, need to be interpreted with caution.
2. **Substance:**
    a. From 2018-2023, the overdose death rate involving fentanyl increased 544.68% (Slide 6) while the death rate involving heroin and Rx opioids decreased 37.5% and 45.34% respectively during the same time period (Slide 5, Slide 7).
    b. In 2023, fentanyl accounts for 77.8% of opioid overdose deaths which is much higher than prescription opioids (20.88%) and heroin (10.05%) (Slide 12).
    c. In 2023, stimulants are frequently present fentanyl overdose deaths (Slide 13).
    d. The amount of fentanyl seizures in kilograms is associated with the number of overdose deaths involving fentanyl from 2018-2022 (Slide 20).
3. **Location:**
    a. Target those residing in 89101, 89145, 89169, 89104, and 89119 ZIP codes (Slide 8) or 3200300302 and 32003001200 Census Tracts (Slide 32) as these are the locations where a high proportion of individuals lived who have died from an opioid overdose in 2023.
        i. Target those living downtown, Washington & H St, and UNLV (Flamingo & Paradise) as these are the locations where a high proportion of individuals resided who have died from an opioid overdose in 2023 (Slide 10).
    b. Target downtown, 13th & Stewart, Naked City/Arts District, and UNLV as these are the overdose locations where a high proportion of fatal opioid overdoses occurred in 2023 (Slide 11).
    c. Target people residing in homes/residences as these are the locations where the majority of opioid overdose deaths occurred in 2023 (Slide 16).
    d. Target 32003001200 Census Tract (Charleston & LV Blvd) as this is the location that Incorporate Social Vulnerability Index and Opioid Overdose Mortality (90^{th} percentile in each) in 2023 (Slide 33).
4. **Time:**
    a. Target initiatives/interventions on Saturday & Sunday around 2:00 PM as those days/times register the most opioid overdose deaths in 2023 (Slide 18). It's important to note that it may take many hours before an individual is pronounced dead.
    b. Target Thursday (across the week) as the day with the highest frequency of fatal opioid overdoses in 2023, when factoring in the Social Vulnerability Index and Opioid Overdose Mortality (90th percentile in each) (Slide 35). It's important to note that it may take many hours before an individual is pronounced dead.

Summary: Non-Fatal Data

1. **Demographics:**
    a. Target individuals who are men and reside in the city of Las Vegas since these individuals have a higher odds of dying from an opioid overdose in 2023 (Slide 28).
    b. Target individuals who are men (Slide 22, Slide 24), people who are White (Slide 22), American Indian/Alaskan Native (Slide 25), non-Hispanic (Slide 23), and individuals aged 25-34, 35-44, and 45-54 (Slide 23) as these groups have much higher opioid ED visits compared to other groups in 2023. Note: Data in Slide 22 and Slide 23 are derived from count data; therefore, need to be interpreted with caution.
2. **Location:**
    a. Target individuals who reside in Las Vegas as this group has much higher rate for opioid ED visits compared to other groups in 2023 (Slide 24).
    b. Target the downtown, Rainbow & Charleston, Arts District/Naked City, and Boulder Highway as these are the locations where clusters of non-fatal opioid overdose occurred in 2023 (Slide 27).
3. **Time:**
    a. Target initiatives/interventions on Tuesdays as this is the day throughout the week with the highest frequency of non-fatal opioid overdose throughout 2023. Additionally, target initiatives/interventions around 1:00 PM and 3:00 PM (Slide 26).

Summary: Naloxone Data

a. Due to the fact that men have a higher burden of opioid overdose compared to women (Slide 14, Slide 19, Slide 22, Slide 24, Slide 28), naloxone is being used on men more frequently than women.
b. SNHD's outreach team distributes naloxone to populations that administer naloxone primarily to people on the street/outside whereas SNHD's distribution to first responders and community agencies administer naloxone to people in residences, businesses, and people on the street/outside. As a result, it is essential to distribute naloxone across diverse agencies, organizations, and outreach teams to effectively reach a broad spectrum of populations requiring naloxone (Slide 39, Slide 44).
c. From the data collected by SNHD, greater than 84% of opioid overdose events requiring naloxone needed 1-2 4mg doses of naloxone (Slide 41, Slide 45).

References

- CDC/ATSDR social vulnerability index (SVI). (2024). Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/index.html
- HIDTA (2023). (rep.). Nevada HIDTA Drug Threat Assessment 2023.
- Southern Nevada Health District (2024). Drug overdose data prepared by Office of Informatics and Epidemiology (OIE) using Nevada Electronic Death reporting System (NV-EDRS).
- Southern Nevada Health District (2024). Drug overdose data prepared by Office of Informatics and Epidemiology (OIE) using ESO.
- Southern Nevada Health District (2024). Drug overdose data prepared by Office of Informatics and Epidemiology (OIE) using Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE).
- Southern Nevada Health District (2024). Drug overdose data prepared by Office of Informatics and Epidemiology (OIE) using Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index (SVI).

Appendix H

Fentanyl Awareness Summit

May 9, 2023

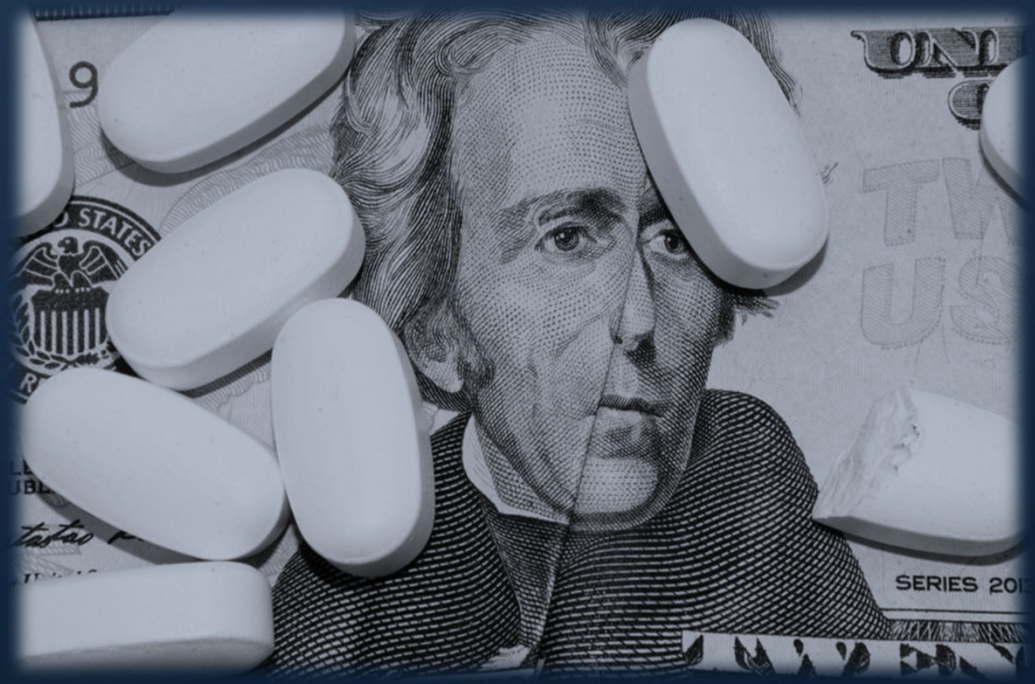
#RiskItAllWithFentanyl

The Opioid Epidemic

Principles for Opioid Settlement Spending

1. Save Lives
2. Use evidence to guide spending
3. Invest in youth prevention
4. Focus on racial equity
5. Develop a fair and transparent process

****Don't use the funds for something Medicaid can cover; use it for things Medicaid and other federal funds can't pay for ****



Source: Bloomberg Overdose Prevention Initiative

#RiskItAllWithFentanyl

HENDERSON

The State's Funding Priorities

- Capacity Building
- Prevent the Misuse of Opioids
- Reduce Harm Related to Opioid Use
- Provide Behavioral Health Treatment
- Implement Recovery Communities across Nevada
- Provide Opioid Prevention and Treatment Consistently across the Criminal Justice and Public Safety Systems
- Provide High Quality and Robust Data and Accessible, Timely Reporting

HENDERSON™

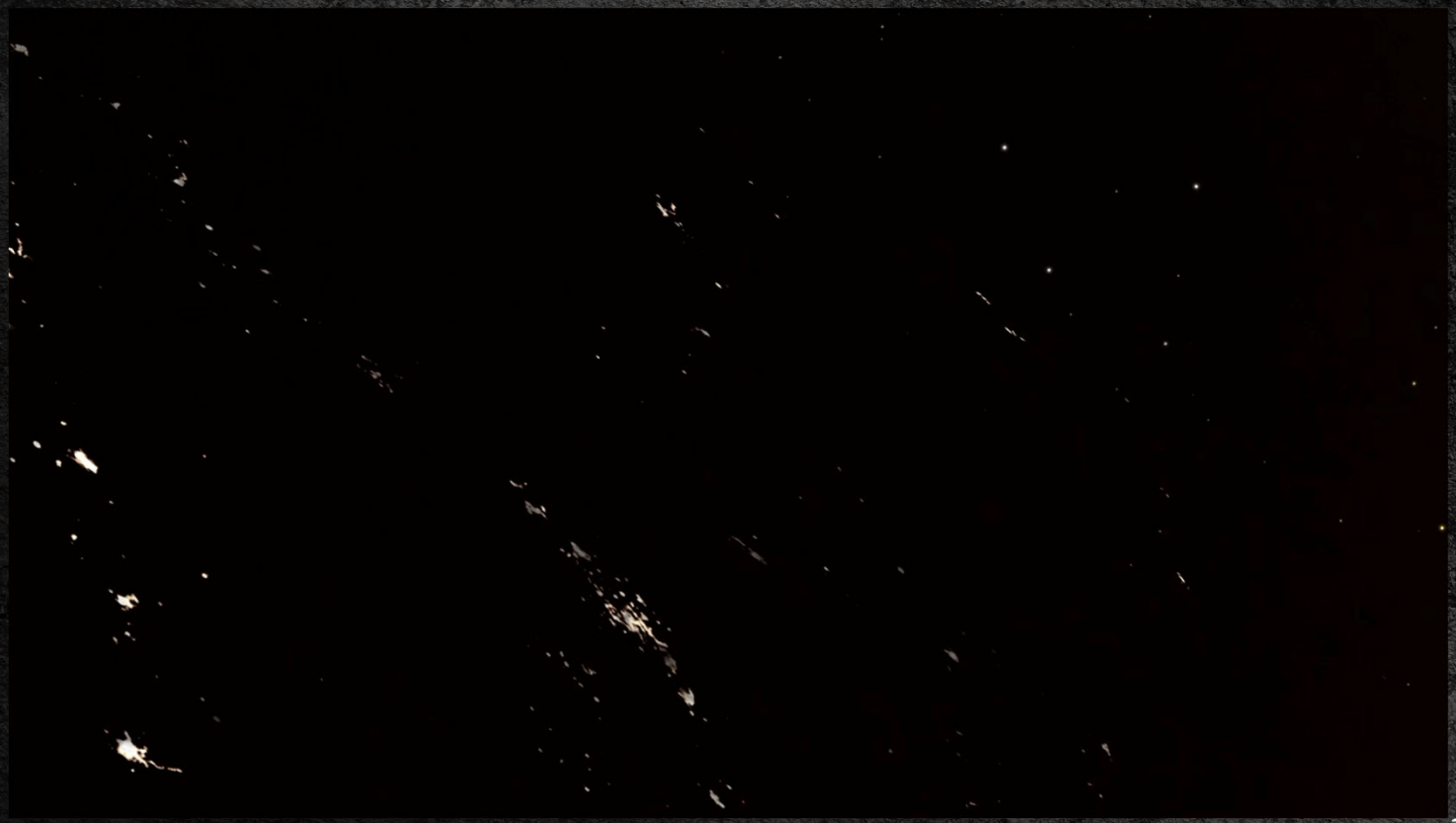
City Needs:

- **Youth Prevention** ☑
- Case management and discharge planning
- Sober living facilities
- Housing assistance
- **Treatment & Peer Support** ☑
- Drug testing
- **Crisis Intervention, Harm Reduction Training & Supplies** ☑

YOUTH PREVENTION

HENDERSON™

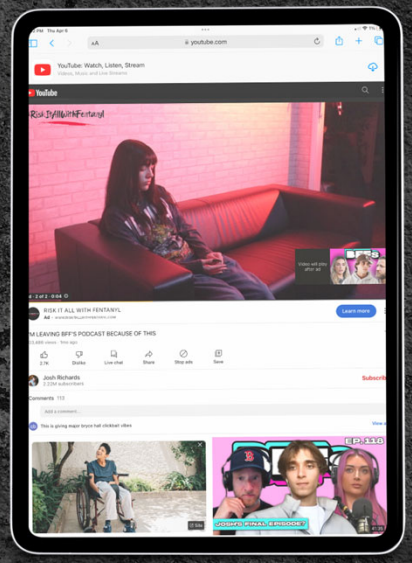
Fentanyl is Changing Everything Video



#RiskItAllWithFentanyl

TT/YT/TikTok, YouTube and In Game Ads

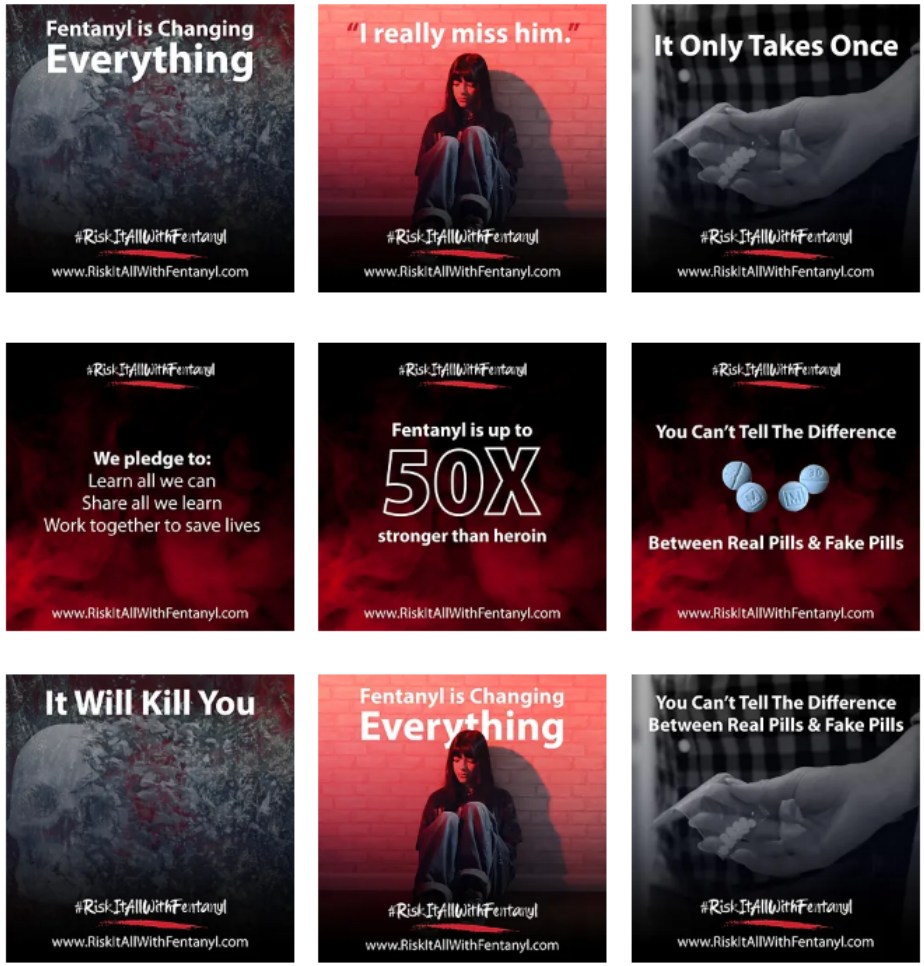
In Game Advertising



YouTube Advertising

TikTok Advertising

#RiskItAllWithFentanyl



RiskItAllWithFentanyl.com

Digital Toolkit Dissemination

Additional Strategies

- Organic marketing placements
- Earned media placements
- Grassroots activations
- Community collaboration

#RiskItAllWithFentanyl

Crisis Intervention & Harm Reduction

Henderson Mobile Crisis Intervention Team (MCIT)


Questions?

#RiskItAllWithFentanyl

Risk It All with Fentanyl Awareness Campaign
Agenda Item Backup Materials
Opioid Task Force
4.18.24 @ 2p.m.

Awareness Campaign Website:
https://www.riskitallwithfentanyl.com/

Toolkit & Train the Trainer:
https://www.riskitallwithfentanyl.com/toolkit

City of Henderson Background Information:
https://www.cityofhenderson.com/our-city/fentanyl-awareness#ad-image-0

Appendix I

Presentation to the Clark County Opioid Task Force

Nevada Opioid Treatment Association

Erin C. Donohue

MSW, CADC, PRSS

CTC Regional Director

Disclosures

NOTA is an association that encompasses 12 facilities, which include both for-profit and non-profit entities. Funding varies from facility to facility, leading to different financial interests based on their funding sources and operational models through grants, Medicaid, Medicare, and private insurance.

Nevada Opioid Treatment Association

The mission of the Nevada Opioid Treatment Association (NOTA) is to unite and empower opioid treatment providers (OTPs) in Nevada. Through these efforts, NOTA will make a positive impact on the lives of those affected by opioid use disorders, creating a healthier and more resilient Nevada community.

We are 6 OTP providers who offer services through 12 opioid treatment facilities throughout Nevada.

- ***Acadia Healthcare Comprehensive Treatment Centers***
- ***Behavioral Health Group***
- ***Desert Treatment Clinic***
- ***The Life Change Center***
- ***New Beginnings Counseling Centers***
- ***Dr. Miriam & Sheldon G. Adelson Clinic for Drug Abuse Treatment and Research***

Opioid Treatment Providers

- OTPs are an organized ambulatory addiction treatment service for patients with an opioid use disorder (OUD). OTPs are heavily regulated by federal and state agencies.
- OTPs involve direct administration of medications on a daily basis without the prescribing of medications.
- Even “take-home” supplies originate at the “dispensing window” of the OTP and do not involve prescriptions taken to a retail pharmacy.
- OTPs provide a collection of services that includes:
  - Medication
  - Level 1 Outpatient counseling
  - Level 1 Ambulatory Withdrawal Management
- OTPs typically utilize methadone, buprenorphine formulations, or naltrexone.
- Treatment is delivered by a medical and clinical team trained in the treatment of OUD.

CCROTF Mission

The Clark County Regional Opioid Task Force reviews available data, in particular, **information relating to harm reduction and substance abuse**.

Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and **identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse**.

NOTA Alignment with SURG & CCROTF

Through these actions, NOTA aligns with the goals of CCROTF:

- **Supporting Harm Reduction Efforts:**
  - Providing education on overdose prevention.
  - Distributing naloxone and harm reduction supplies to patients and non-patients.
  - Collaborating with stakeholders such as DHHS, UNR, UNLV, CASAT, and TRAC-B for sustainable funding of naloxone distribution programs.
- **Providing Access to Medications for Opioid Use Disorder (MOUD):**
  - Offering evidence-based treatment with medications like methadone, buprenorphine, and naltrexone.
  - Acting as a hub in a hub-and-spoke system, providing MOUD and wrap-around services.
  - Engaging in telehealth SUD counseling programs, initiating OUD programs through telehealth based on CFR 42 part 8 final rule.
- **OTP Service Offerings for Patients with SUD:**
  - Providing bundled services including medication, Level 1 Outpatient counseling, and Level 1 Ambulatory Withdrawal Management.
  - Utilizing a team of trained personnel including physicians/prescribers, nurses, licensed or certified addiction counselors, and mental health counselors.
  - Delivering patient-centered and recovery-oriented individualized treatment, case management, and health education.
- **Responding to Suspected Overdoses:**
  - Collaborating with law enforcement and public health agencies for hand offs and comprehensive care.
  - The study confirms that using methadone and buprenorphine to treat OUD effectively reduces mortality among patients who have experienced a nonfatal opioid overdose.
- **Preventing Generational Cycles of Addiction:**
  - Implementing programs for families, including prenatal and neonatal care.
  - Supporting caregivers with parenting skills to break the cycle of addiction.
  - Reducing the overall burden of substance use disorders in communities through evidence-based methods.

Patient Journey of Care

Patient Intake

- *Intake interview*
- *Physical exam with a licensed physician*
- *Psychosocial evaluation*
- *Toxicology screening*

Treatment Plan

- *A team of trained professionals develops a tailored treatment plan to help stabilize drug use, reduce withdrawal symptoms, and teach skills to resist relapse.*

Start Recovery Journey

- *Begin the journey to recovery with daily medication for opioid use disorder (MOUD).*
- *Attend weekly in person or virtual counseling sessions.*
- *Start treatment for co-occurring conditions.*

Maintain and Sustain

- *Continue the path to recovery with ongoing support, gradually extending intervals between clinic visits while learning and testing new coping skills and behavioral strategies.*
- *Take part in connecting with wrap around supports and set up for success.*

OTPs are safe, stigma free places for special populations to receive treatment

Many of OTP clientele are members of special populations including:

- *Lower socioeconomic status*
- *Unhoused population*
- *Pregnant women and parents with children in the household*
- *IV drug users*
- *Veterans, elderly persons*
- *Persons who are incarcerated*
- *Persons with co-occurring mental health disorders*
- *Victims of domestic violence*

What's Working Well / Evidence Based Practices

Access to medication for opioid use disorder (MOUD)

Contingency management

Accessing counseling

Psychiatric and behavioral healthcare

Case management

Peer Recovery Support Services

Working with community partners

Issues: Driven by insufficient payment rates

- **Oral Medication Administration Rates:** Oral medication administration is currently billed at $3.94, a rate unchanged since 1980.
- **Limited Clinic Hours:** Clinics are unable to operate for extended hours due to financial constraints.
- **Unstable Staffing:** High turnover and difficulty retaining qualified staff impacts the quality of care.
- **Limited Reimbursement for Peer Recovery Support Specialists:** Funding shortfalls restrict the availability of these essential support services.
- **Additional Issues:**
  - **Transportation Challenges:** Clients face difficulties accessing treatment due to inadequate transportation options.
  - **Lack of Services in Rural Communities:** Rural areas suffer from a severe lack of available treatment services.

Gaps

Medicaid reimbursement is currently insufficient to cover the cost of oral administration of medications with the average cost per patient at $15.

On the West Coast, the average reimbursement rate is $12. In comparison, Nevada's reimbursement of $3.94 is only 33% of the western states average.

Peer support services are currently under-compensated and have a low Medicaid reimbursement rate for their valuable work.

Clients face difficulties accessing treatment due to inadequate transportation options.

Recommendations

- *State Medicaid*
  - *Increase reimbursement rates for oral administration of medications*
  - *Inclusion of peer recovery support specialists*
  - *Create service 'bundles' for OTP billing efficiency and comprehensive treatment*

- *Clark County Supports*
  - *Pairing OTP with other forms of harm reduction and treatment*
  - *Introduce more OTP programs to jails and prisons*
  - *Address transportation challenges*
  - *Use of peers for outreach and retention*

Acronyms

MAT	Medication Assisted Treatment
MOUD	Medications for Opioid Use Disorder
OTP	Opioid Treatment Providers
OUD	Opioid Use Disorder
SUD	Substance Use Disorder
NOTA	Nevada Opioid Treatment Association

Questions?

&

Thank You!

Contact Information

Erin Donohue
Erin.Donohue@ctcprograms.com

John Firestone
johnfirestone@tlccreno.org

Morgan Biaselli
morgan@ssgr.us

Sarah Adler
sarah@ssgr.us

References

- CASAT. “Certification Process.” *Behavioral Health NV*, behavioralhealthnv.org/about/.
- “2023 Annual Report of the Statewide Substance Use Response Working Group (SURG).” *Office of the Attorney General*, 1 Jan. 2024, ag.nv.gov/uploadedFiles/agnvgov/Content/About/Administration/07.12.23%20SURG%20Meeting%20Notes%20Draft.pdf.

Appendix J

CrossRoads of Southern Nevada

ADDRESSING THE OPIOID EPIDEMIC

www.crossroadsofsonv.com

OVERVIEW INFO

- Opened in 2018
- Current Levels of Care Offered: 3.7 Medical Detox, 3.5 Residential Treatment, 3.2 Withdrawal Management, 2.5 Partial Hospitalization, 2.1 Intensive Outpatient, 1.0 Outpatient.
- Bed Availability
  - 74 Medical Detox / WM
  - 104 Residential
  - 12 Veteran-Specific
  - 160 Housing
- Certifications / Accreditations
  - The Joint Commission
  - Substance Abuse Prevention and Treatment Agency (SAPTA)
  - Health Care Quality and Compliance (HCQC)

LET'S TELL THE STORY

DETOX

- Inpatient Screening & Chart Creation
- Triage (drug test / breathalyzer, shower, medical assessment, meal, clinical assessment)
- Clinical, Nurse, & Doctor determine LOC placement
- OUD Detox Stay: Traditionally 5-7 Days
- H&P, Peer Support, and Clinical within 24 hours
- Case Management on Day 2
- Rounds hourly (BHTs) and every 2 hours (Medical)
- Daily Treatment Plan
  - Peer Support Specialist & Clinical Groups
  - MAT Conversations
  - Medication / Medical Team Contact

RESIDENTIAL

- Clinically managed 24/7 inpatient care
- 25 hours of structured programming per week
- Groups 4 days per week
- Individual sessions based on treatment plan
- Case Management begins process of obtaining vital docs, coordinating medical providers for post discharge, and ongoing treatment/housing options.
- Peer Support Specialist daily groups and individual meetings weekly.
- Additional assignments given to be completed in between clinical sessions:

LET'S TELL THE STORY

OUTPATIENT WITH HOUSING

- Partial Hospitalization
  - 2-4 weeks
  - Groups 5 days per week
  - Weekly individual sessions / case management / peer support
  - Assigned Accountability Buddy in Housing
  - Begins "What Do I Do Now?" Workbook
- Intensive Outpatient
  - 6-8 weeks
  - Groups 3 days per week
  - Can now lead as a Buddy in Housing
  - Bi-Weekly individual sessions
  - Continued weekly case management and peer support
  - Housing Curfew of 10pm

POST-COMPLETION

- Staff contact with clients monthly
- Client has option to continue at Level 1 Outpatient with 1x weekly group, 1x monthly individual session, and 1x monthly case management.
- Alumni meetings once monthly.
- Alumni activity events once per quarter.
- Surveys sent to clients 6 months after completion from IOP/Housing
- Re-engagement in services if needed based on any changes to circumstances.

TREATMENT

CrossRoads of Southern Nevada has made numerous changes over the last 18 months in order to better support individuals whom are coming into treatment in one of our levels of care. Individuals with opioid use disorder (OUD), especially with active fentanyl use, need additional supportive services. 68% of individuals entering CRSN have opioid use in the last 14 days.

AWARENESS

CRSN has become a hub for OUD awareness in the community. Our outreach efforts and community involvement focus on engaging individuals in educational conversations and offer them solutions to problems affected by opioid use. CRSN Staff is also kept up to date on trends.

CrossRoads of Southern Nevada

TREATMENT & PROGRAMS

HARM REDUCTION
POLICIES & PROCEDURES

Policy & Procedure changes to specifically address opioid use:

- Medical Detox Response to Opioid Use Disorder (OUD)
  - Added continuation of methadone for those established on it prior to admission vs detoxing off all substances.
- Discharge Protocols / Resources
  - Adjusting treatment plans for increased care after relapse rather than an immediate discharge.
  - Ensure medication-assisted recovery friendly options were available for those wanting to continue on maintenance doses.
  - Care coordination for continued medication-assisted treatment post-discharge.
  - Provide overdose prevention training and kits for those with opioid use.

HARM REDUCTION
POLICIES & PROCEDURES

- Naloxone Administration / Dispensing
  - Set specific procedures so all staff can recognize signs & symptoms of opioid overdoses & respond with Naloxone.
  - All staff trained quarterly to be able to dispense naloxone to those at risk of an opioid overdose or friends/family of those at risk.
- Program Re-Entry Guidelines
  - Adjusted readmission protocols for opioid-using individuals with numerous treatment attempts.
    - Medical Director involved in all cases of opioid readmissions.
    - Expanded programming to delineate 3.7 LOC from 3.2 LOC to increase capacity for 3.7 admissions.
- Medication - Assisted Treatment Discussions
  - All clients with opioid use are offered MAT options during intake, throughout care, and post-discharge.

MEDICATION ASSISTED TREATMENT OPTIONS

Prior to 2023, CRSN provided opioid-using clients with the options of Buprenorphine (during stay) and Naltrexone products (upon discharge / in outpatient).

In order to provide clients with methadone, a facility must obtain an Opioid Treatment Provider (OTP) license due to regulations surrounding methadone treatment for opioid use disorder.

However, clients can maintain their status at a local OTP and seek admission into detox for continued opioid use or other substances.

MEDICATION ASSISTED TREATMENT OPTIONS

CRSN has established partnerships with several local OTPs to now offer detox for methadone clients without having to cease their medication.

CRSN offers the following options throughout care and appropriate treatment decisions are made between the doctor and client.

- Buprenorphine (oral and injectable)
- Naltrexone (oral and injectable)
- Methadone via community providers

CRSN also onboarded a Medical Director in 2023 with over a decade of experience with MAT.

FENTANYL TESTING ON SITE

With fentanyl overdose rates increasing by 50% in Clark County in the last 3 years, CRSN partnered with Sober Testing Services to begin testing all medical detox admissions regardless of reported drug of choice. Additionally, all outpatient/housing clients are tested for fentanyl on their random screenings. CRSN is the only facility in the city testing for fentanyl on all drug screens.

Since implementation in 2023, nearly half (48%) of individuals reporting no opioid use upon admission assessment are testing positive for fentanyl. Results are received within 4 hours. This changes their course of care from being observation based to needing medical interventions such as medication.

OPIOID USE CURRICULUM IN PROGRAMS

CRSN's clinical staff ensures that individuals with opioid use disorder are given additional therapeutic support through the following curriculums:

- Living in Balance / Matrix Clinical Curriculums
  - Comprehensive Life Skills - Structured sessions on stress management, relationships, and coping mechanisms, essential for maintaining sobriety.
  - Evidenced-Based Techniques - Uses Cognitive Behavior Therapy, motivational interviewing, and relapse prevention strategies to address substance use cases and prevent relapse.
  - Holistic Approach to Recovery - Addresses physical, emotional, social, and spiritual aspects for balanced, fulfilling life free from opioid dependence.

OPIOID USE CURRICULUM IN PROGRAMS

CRSN has also began to implement “What Would I Do Now?” Moral-Reconation Therapy:

- 12 week specialized workbook targeting opioid-focused drug courts, medically-assisted treatment clients, and offenders in treatment with opioid related issues.
- This program ensures clients maintain engagement during the first 90 days of treatment.
- Fosters an ongoing relationship with treatment after the initial 90 days.
- The workbook has an open-ended format, allowing clients to start at any time and complete sessions at their own pace.
- Only requirement is weekly interaction with staff.

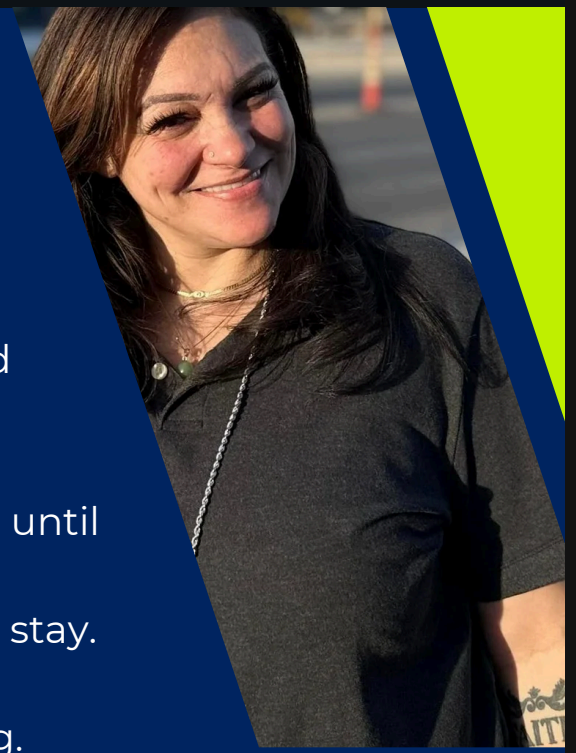
PEER SUPPORT WITHIN PROGRAMS

Peer Support Specialists, individuals with lived experience, are integrated into treatment support throughout all programs - including conducting peer lead groups, assisting with those wanting to leave treatment against medical advice, attending mutual aid meetings with clients, and planning sober social events.

Per Faces and Voices of Recovery (FAVoR), the use of peers in treatment settings increases completion rates, length of sobriety post-discharge rates, and improves stress response to crisis.

These peers all have prior history with opioid use and are able to share their personal journeys to establish meaningful connections with clients.

PEER SUPPORT WITHIN PROGRAMS



Statistics on CRSN Peer Recovery Support Specialist (PRSS) and Opioid Using Clients (Jan, 2024 - present):

- 78% of clients meet a PRSS within the first 24 hours of detox.
- 53% success rate in blocking AMAs (getting them to remain in care until completion).
- 35% of clients attend PRSS-led groups every day during their detox stay.
- 82% of clients attend at least one PRSS-led group during detox.
- 76% of clients are attending PRSS-led groups in outpatient/housing.
- 80% of clients reported having access to a PRSS during their treatment made them feel more comfortable in their recovery environment.
- Clients are 3x more likely to remain in care until completion if they have contact with a PRSS during their course of their treatment.

RECOVERY FRIENDLY WORKPLACE

CRSN has been designated as a Recovery Friendly Workplace meaning CRSN:

- Engages all employees in education about substance use disorder and prevention.
- Holds space for mutual aid meetings on site.
- Encourages healthy activities outside of work hours.
- Hires individuals with lived experience in all departments.
  - 75% of CRSN employees identify as in recovery.
  - More than half of those employees have self-disclosed having a history with opioid use.
- Has a dedicated relapse prevention plan for employees vs a punitive termination plan.

CRSN HOUSING
MAT FRIENDLY

CRSN's housing program accepts all forms of MAT.

Staff are trained in MAT education and how to properly monitor clients whom are on MAT.

Mutual aid meetings held on site are non-discriminatory to support those on medications (HA, NA, SMART, MRT).

During treatment, clients on MAT treatment are giving additional support on coping skill education, medication compliance, and positive peer interactions.

CRSN HOUSING
MAT FRIENDLY

20% of current housing clients are on MAT medications.

100% compliance rate with medication administration.

Staff support clients whom are on methadone by coordinating delivery of medication or daily transportation to their medication provider.

Case Managers ensure that upon discharge from CRSN housing, clients are given options that will continue to support their recovery path such as MAT friendly sober living and independent housing.

CRIMINAL JUSTICE & LAW ENFORCEMENT

CRSN is a preferred partner for numerous criminal justice and law enforcement entities whom encounter individuals with Opioid Use Disorder.

Partners:

- Las Vegas Metro Police / Fire & Rescue
- AMR
- Medic West
- Clark County Detention Center
- LIMA (Law Enforcement Intervention for Mental Health & Addiction)
- Courts: 8th Judicial District, Las Vegas Justice Court, Henderson Municipal, Las Vegas Municipal Court, and Boulder City Drug Court

MAT RE-ENTRY COURT

CRSN plays an integral role in the 8th Judicial District's MAT Re-Entry Program, which was established in 2017. This specialty court allows individuals releasing from incarceration onto Parole, or early release through the 184 Program (outpatient incarceration with NDOC), to engage in supportive services that are inclusive to MAT options.

All participants are met with within 72 hours of release from incarceration to be educated on MAT options post-release. Any individual whom initially denies medication but later relapses, is reassessed for care. This court focuses on harm reduction vs. discplinary action.

CRSN has been both a treatment and housing provider for the program since inception, the first of its kind in the nation. Dedicated staff hold key positions on the specialty court treatment team.

MAT RE-ENTRY COURT

Overall Court Statistics

- 310 Clients since December 2018
- 50% of Participants have an Opioid Use Disorder Diagnosis
  - Initial funding was Opioid Use Only, changed in 2021
- 98% of clients maintained abstinence at minimum 6 months
- 67% Successful Completion Rate

CRSN MAT Court Statistics:

- 84% Successful Completion Rate
- 87% received ID, 94% received birth certificate / SS card
- 97% obtained insurance
- 66% obtained stable employment

COMMUNITY CONTINUITY

CRSN has established partnerships to act as a diversion site for higher levels of care using impeded organizations in Emergency Rooms such as WellCare and HBI.

The purpose of this relationship is that neither organization provides detox / partial hospitalization programming traditionally needed for long term high risk opioid users.

The program is designed to accept clients from the ER setting, through authorizations. Clients attend 3-10 days of detox and 2-4 weeks of PHP programming. CRSN then returns the client to Wellcare / HBI after PHP for continued supportive care along with OUD treatment provided by those agencies and their associated MCO.

CrossRoads of Southern Nevada

STAFF & COMMUNITY AWARENESS

NARCAN AND FENTANYL TEST STRIP

DISTRIBUTION SITE

All CRSN locations are now distribution sites to the community for Naloxone and Fentanyl Test Strips.

Individuals regardless of status with CRSN can present to any location and obtain overdose prevention kits while providing minimal to no personal information.

To date, over 3,000 doses of Naloxone and 2,000 fentanyl test strips have been distributed from CRSN facilities.

HARM REDUCTION AND OVERDOSE PREVENTION

EDUCATION

CRSN Staff is required to attend harm reduction and overdose prevention training on a quarterly basis.

CRSN hosts FREE community trainings on a bi-monthly basis, covering both topics, and providing attendees with Certificates of Completion and Overdose Response Kits.

Since January, 2023, 1,852 individuals have attended these trainings.

COMMUNITY

PARTNERSHIPS

CRSN prides itself on being a preferred partner for several community organizations to accept direct referrals for individuals with opioid use disorder:

- Anthem
- WellCare
- Molina Healthcare
- Human Behavior Insitute
- NV Division of Welfare and Supportive Services
- NV Department of Employment, Rehabilitation and Training
- University Medical Center
- EMPOWERED Program / High Risk Pregnancy Center
- University of Nevada Las Vegas / Nevada State College
- Behavioral Health Group / Adelson Clinic
- Trac B Exchange

COMMUNITY EVENTS

CRSN hosts job fairs in partnership with DWSS to assist participants and community members to find job training programs and/or stable employment. These fairs average between 40-50 individuals being hired on the spot and over 125 being offered interviews / job training programs. Of those hired on the spot, over half (52%) have been diagnosed with an Opioid Use Disorder in the last 12 months.

In September, 2023, Six staff members represented the state of Nevada in Washington, DC at the national Mobilize Recovery Conference, meeting with legislators on the current status of the opioid epidemic in Nevada.

“Narcan at Night” was established in September as a city wide effort to get overdose response kits in the hands of our most vulnerable population. Over 1,500 doses were distributed in one day!

Along with LV PRIDE, CRSN formed the first ever Recovery Village at the local event in October, 2023. An additional 4,000 doses of Narcan were dispensed during the parade and festival.

LOCAL OUTREACH TEAMS

CRSN has a designated outreach team that is available to community providers, such as law enforcement and hospitals, for transportation to treatment and care coordination.

Our Street Outreach team canvases well known community roads, in partnership with Shine A Light Foundation, 7 days per week to provide resources, supplies, and connection to treatment. All individuals encountered receive overdose prevention kits and a brief overdose prevention training.

In 2024, 148 individuals have entered treatment with CRSN after being found in the Las Vegas flood tunnels. 45% of them had opioid use within the last 30 days.

PENDING LEGISLATION

MONITORING

CRSN has a dedicated Executive Team, whom are monitoring pending legislation that can only further enhance internal programming or community involvement.

Current legislation being monitored includes:

- Opioid Treatment Provider Licensure Requirements
  - Would remove license requirement so all facilities are able to provide methadone as a MAT option for individuals with opioid use.
- Safe Consumption Sites
  - Harm reduction facilities where substance can be tested, individuals can be assisted with use, immediate medical response to overdoses, and connection to services if ready to engage in recovery process
  - Treatment providers are onsite to transport if an individual determines they are ready for treatment. CRSN would be motivated to partner with these programs.
- Sobering Center Locations
  - Medically run facilities to divert intoxicated individuals from Emergency Rooms/ Jails
  - CRSN Outreach teams are focused on connecting these individuals with long term treatment/recovery options.

CONTACT INFORMATION

JAMES JUNE
VP of Programs

James.J@Crossroadsofsonv.com

LAUREN GRIFFY
VP of Operations

Lauren.G@Crossroadsofsonv.com

CrossRoads of Southern Nevada

THANK YOU

FOR YOUR ATTENTION

Appendix K

CCBHC: REMOVING OBSTACLES, ADDING SERVICES

Responding to need:

- Intensive Outpatient Program (IOP)
- Trauma & Other EBP Training
- Outreach – Veterans & Communities
- Detox & Inpatient Housing

Responding to Crisis:

- 1 October Route 91 Mass Shooting
- COVID-19 Pandemic
- 24/7 Crisis Call Response

SUSTAINABILITY

- **Medicaid represents more than half of Bridge's revenue**
- **Credentialed with most local private insurances**
- **Over a dozen grants and contracts assure no client is turned away!**
- **Yes! We offer a sliding fee scale**

COMMUNITY IMPACT

- **Staff: 40+ NV Licensed Clinicians (Employee, Dual Licensed)**
- **Bilingual – Spanish, Dutch, Tagalog, Urdu, German, & French**
- **95% Trauma Trained**
- **Board Certified Psychiatrist / Medical Director**
- **Psychiatric Nurse Practitioner (APRN)-three**
- **Targeted Case Managers and Peer Support Specialists**
- **Practicum and Psych-APRN Students from 8 Universities**

1500 clients currently; 4000 annually

COMMUNITY COLLABORATION

Bridge has over 40 Memoranda of Understanding (MOU):

This includes Veterans, Women's, Youth and Homeless Service Agencies

CURRENT BRIDGE SERVICES

- **Outpatient and Intensive Outpatient Treatment (IOP)**
- **Psychiatric and Medical Treatment**
- **Targeted Case Management and Peer Support Services**
- **Psychosocial Rehab / Basic Skills Training (PSR/BST)**
- **Medication Assisted Treatment (MAT)**
- **Commercial Food Services Kitchen**

UPCOMING BRIDGE SERVICES

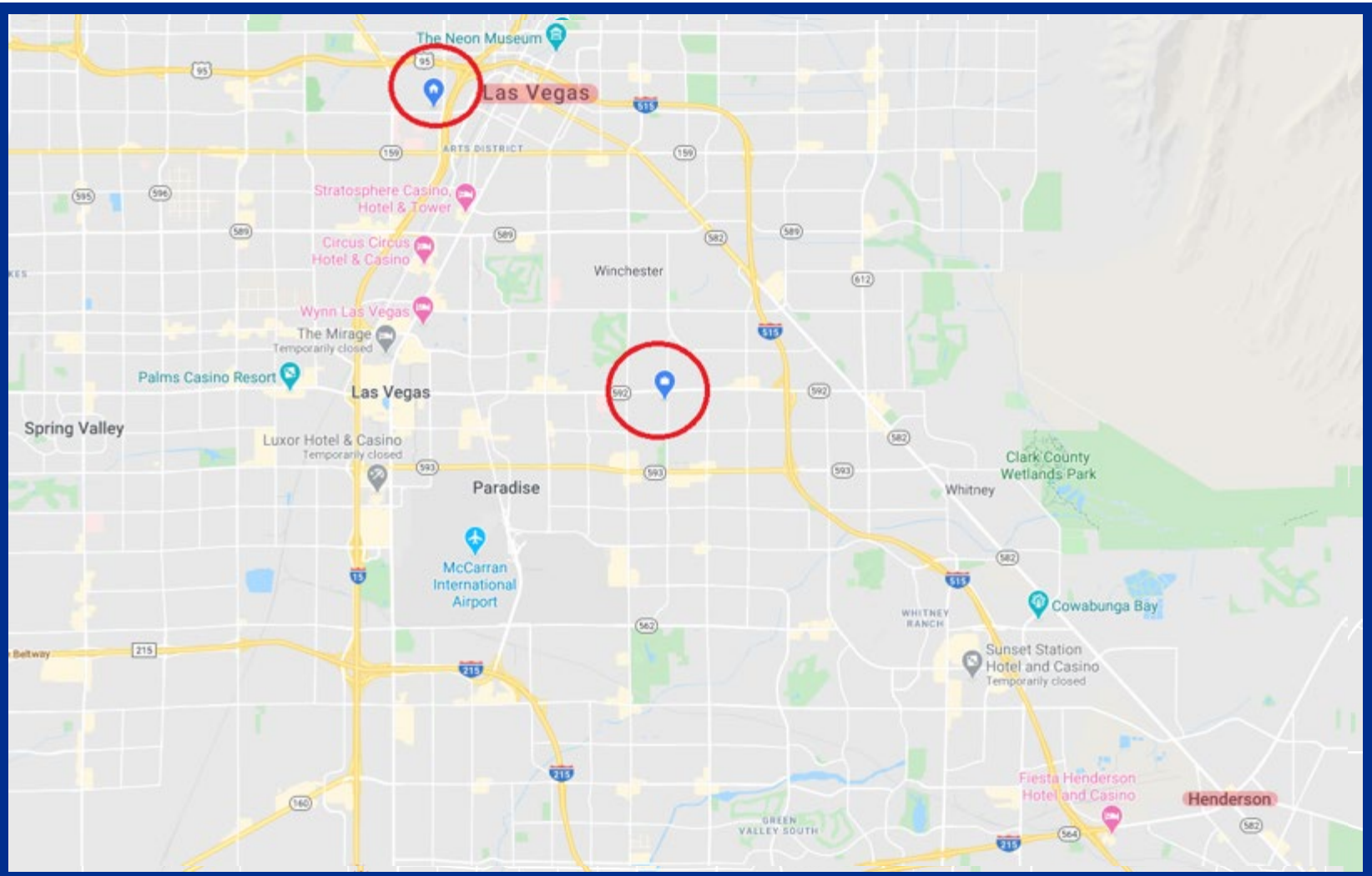
OPEN NOW

- **Residential Treatment Shelter – 48 Beds**
- **Safety Treatment Shelters – 18 Beds**

COMING SOON

- **Medical Detox – Nine (9) Beds**
- **Residential Treatment- 16 Beds**
- **5,000 sq/ft Psychiatric Residential Treatment Facility (PRTF) for Adolescents**
- **100 beds of transitional housing apartments**

BRIDGE CCBHC LOCATIONS



1640 ALTA DRIVE

LOCATED IN LAS VEGAS MEDICAL DISTRICT

415 S 6TH ST (COMING SOON)
LOCATED IN DOWNTOWN LAS VEGAS

4221 MCLEOD @ FLAMINGO
LOCATED IN UNINCORPORATED CLARK COUNTY

SOLVING PROBLEMS

ALL-GENDER RESTROOMS

(1ST FLOOR PUBLIC RESTROOMS)

MEDICAL CLINIC

DETOX

(9 BEDS PLUS NURSES' STATION)

RESIDENTIAL TREATMENT

(16 BEDS & COMMON AREAS)

HOMELESS TRIAGE

48 BED RESIDENTIAL TREATMENT SHELTER

RESIDENTIAL SAFETY SHELTER

(TWO ROOMS TOTALING 18 BEDS)

RESIDENTIAL TREATMENT SHOWERS

STATE LICENSED COMMERCIAL KITCHEN

RESIDENTIAL TREATMENT SHELTER
WATER REFILL STATION / BATHROOMS

TELEHEALTH

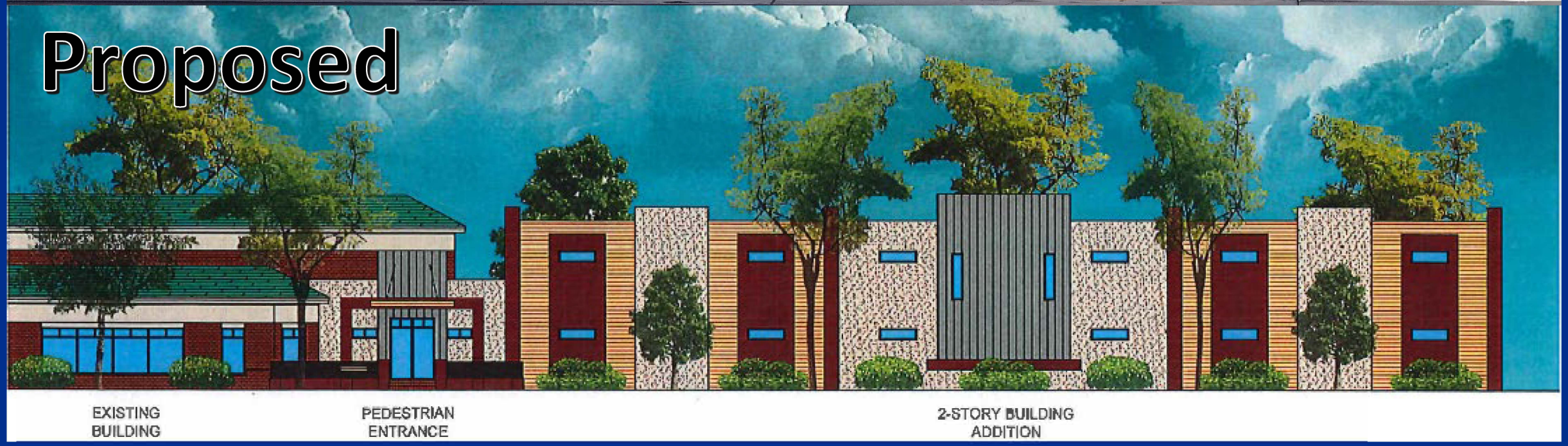
CCBHC WITH APPROVED CDBG PROJECT (4 ACRES)

NEW TRANSITIONAL LIVING SPACE

- **Provides 100 new beds**
  - **50 2-bed transitional apartments for all gender**
- **All supportive services "on-site" today!**
  - **Mental Health / Substance Abuse Treatment**
  - **Psychiatric and Medical Treatment**
  - **Case Mgt. providing: transportation, employment assistance, and permanent housing referrals**

Existing

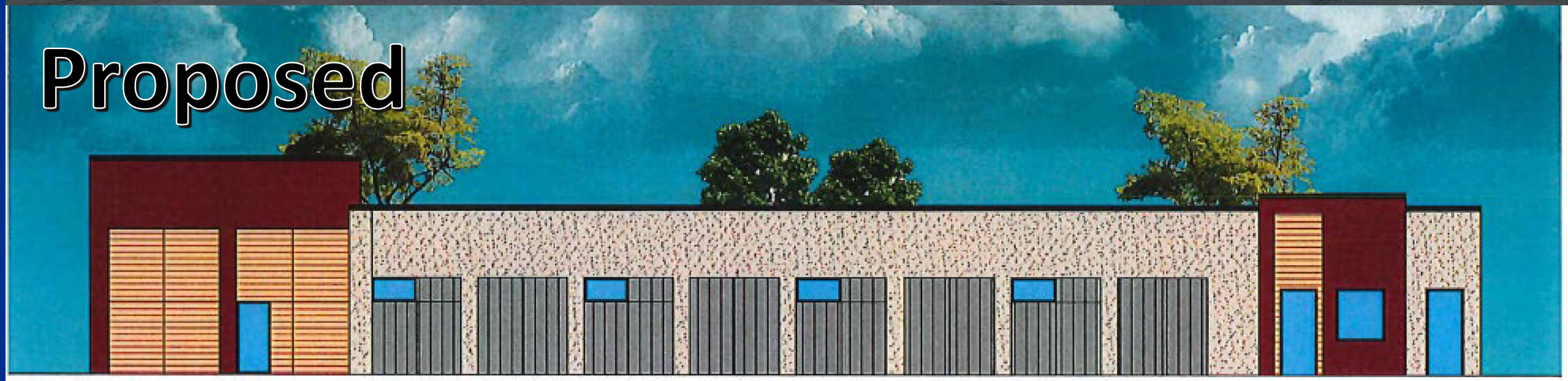
Proposed



PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

- **Beds for up to 16 youth and children under 18 years**
  - **24/7 residential treatment**
- **All supportive services "on-site" at opening!**
  - **Substance Use and Mental Health Treatment**
  - **Psychiatrist and Medical Nurse Practitioner**
  - **Commercial Food Services**

Existing



Proposed

CHILDREN'S
INTERIOR
EXPANSION

CCBHC SUBSTANCE USE DATA

State of Nevada CCBHC Dashboard – Data as of 1/1/24 – all claims/services:

All CCBHCS		Bridge Counseling
16% Related to Alcohol	↑	18% Related to Alcohol
14% Related to Stimulants	↓	6% Related to Stimulants
8% Related to Cannabis	↑	12% Related to Cannabis
6% Related to Opioid	↓	2% Related to Opioid

INTERNAL DATA

3.3% of all clients present with an opioid use disorder

Age Group	Total Population	Opioid Use Population
Adolescent	13.1%	0.3%
Adult 18 Plus	86.9%	3.8%

Gender	Total Population	Opioid Use Population
Female	51.3%	3.3%
Male	47.8%	3.3%
Other	0.8%	5.2%

Race	Total Population	Opioid Use Population
American Indian	0.4%	0%
Asian	1.5%	1.5%
Black or African American	14.8%	1.4%
Hispanic or Latino	43.3%	3.2%
Multiple Race	20.5%	1.7%
Native Hawaiian or Pacific Islander	0.6%	3.8%
White	18.9%	7.1%

LOCAL NEEDS ASSESSMENT

- The Opioid Needs assessment was completed in 2022 and found that there 836 unintentional fatal drug overdoses in 2022, which was a 6.2% increase over 2021.
- Clark County reported the lowest rates of overdose, regionally, at 21.6 per 100,000.
- Nevada's Epidemiological profile's (2022) data indicates 174 per 100,000 Emergency Department Encounters were a result of opioids in 2021; still substantially lower than methamphetamine at 440 and cannabis at 313.
  - Additionally, Drug-related inpatient admissions show shows opioids at 260 per 100,000, Marijuana at 466 and methamphetamine at 466.

This data is in line with the presentation of people seeking treatment at Bridge Counseling -

While opioid treatment and resources (MAT & Narcan distribution) are available they are not heavily utilized.

This has led BCA to focus clinical staff training and resources towards treatment and specialty programing for alcohol, cannabis, and stimulant use.


BRIDGE

Appendix L

First Responder Perspective

Opiate Trends, Access to Resources, Gaps, and Recommendations

Naloxone Training Overview

Protocol based Therapy	• Unresponsive with respiratory depression & suspected narcotic overdose
Dosing	• .4-2mg IN/IM/IV/IO titrated to increased respiratory effort • Max dose 10mg

- Must display indications and receive the smallest effective dose
- Simple and quick to administer

Trends

- ESO- 2023 (SNHD)
  - .4mg delivered 12 times
  - 1mg 329 times
  - 2mg 1736 times
  - 4mg 101 times
  - More than 4mg 16 times (Max 8mg)

Trends

- CCFD-
  - General feeling among Paramedics/EMS staff overdose calls are increasing
  - General feeling among Paramedics more Naloxone is administered per patient
  - Frequency of calls matching Overdose/Naloxone Administration
    - July 1 2022-July 1 2023 333 calls
    - July 1 2023-July 1 2024 667 calls

Access to Resources

- No Challenges accessing resources
- No gaps identified
- Demand for Naloxone increasing nationwide

Recommendations

- Increased Training with nasal administration kits
  - Reports of violent encounters with prehospital administration

- Opportunity for Collaboration
  - Data collection- Targeted therapy within hotspots provided by SNHD with PODS
  - Referral to Core
    - Leverage Nonprofit/NGOs
  - Evaluate-Revise plan

Data Collection

CAD

Primary Cause
Secondary Cause
Other Cause 1
Other Cause 2
Other Cause 3

Work Related

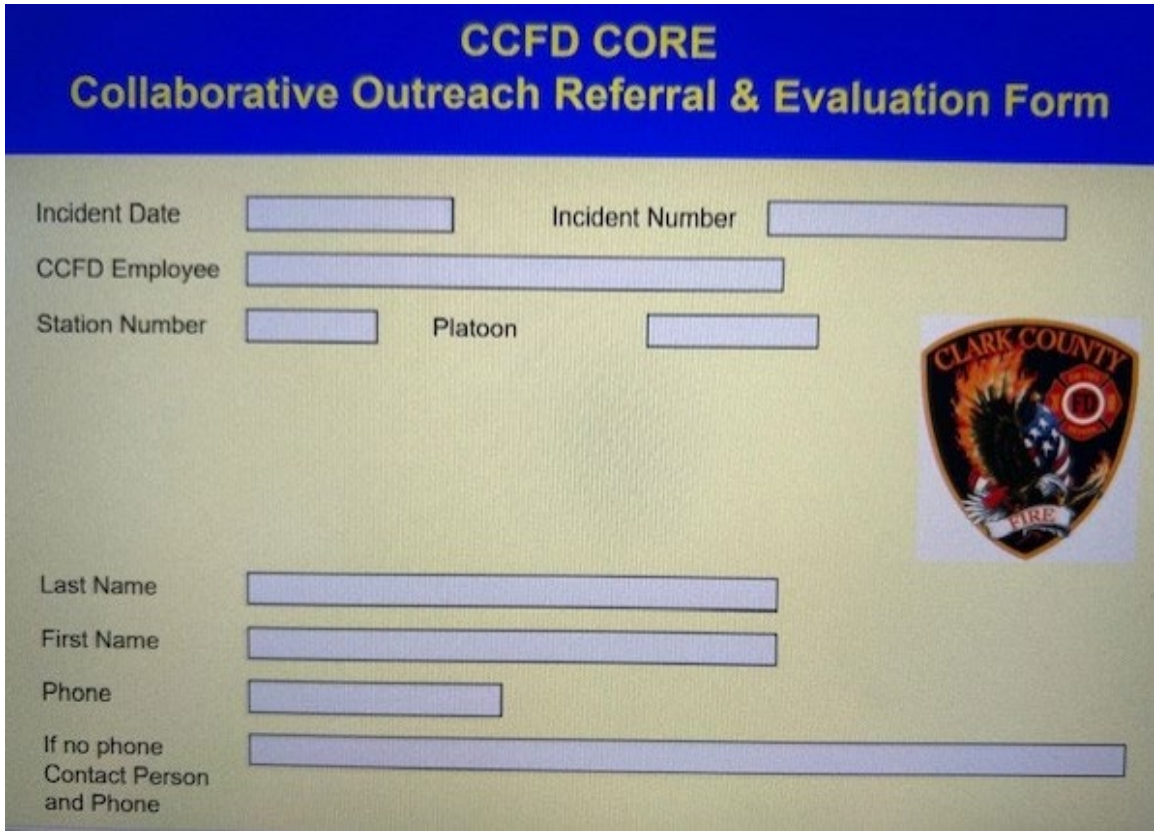
Work Related	Yes	No

Alcohol/Drug Use Indicators

Alcohol Containers/Paraphernalia at Scene	✓	Positive Level known from Law Enforcement or Hospital Record	✓
Drug Paraphernalia at Scene	✓	Physical Exam Indicates Suspected Alcohol or Drug Use	✓
Patient Admits to Alcohol Use	✓	None Reported	✓
Patient Admits to Drug Use	✓	Unable to Complete	✓

PowerFields

Data Collection



Questions?

- Brian O’Neal
- Assistant Fire Chief
- Clark County Fire Department
- boneal@clarkcountynv.gov

Appendix M

Overdose Response Team

(ORT)

A CLARK COUNTY MULTIAGENCY RESPONSE

The Fentanyl Crisis

- Fentanyl related deaths are increasing each year.
  - 2019, there were 72 OD deaths-from Fentanyl.
  - In 2019 fire departments and ambulance services within Clark County responded to 3,249 incidents where Narcan/ Naloxone was administered to a patient.
  - 2020, there were 193 OD deaths- from Fentanyl
  - The Age Range of 18 to 44 years old accounted for 75% of the deaths from 2020.
  - Therefore, a Task Force has been created….

Task Force Composition

- 1 LVMPD SGT
- 4 LVMPD Narcotic Detectives
- 1 HPD Narcotic Detective
- 1 HSI Special Agent
- DEA liaison
- 1 HIDTA Analyst
- The Southern Nevada Post-Overdose Response Team (SPORT)

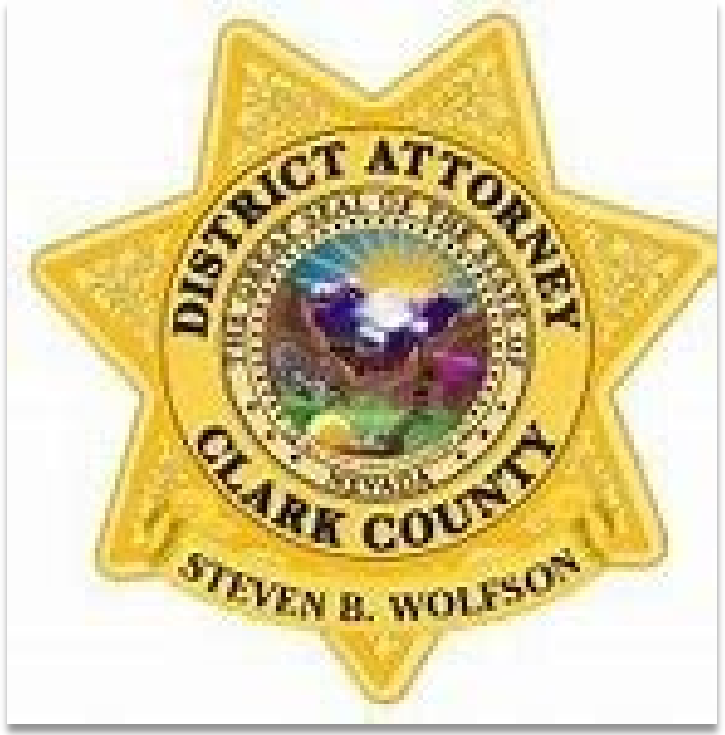
Overdose Response Team

(ORT)

- IT IS THE POLICY OF THIS TASK FORCE TO INVESTIGATE OVERDOSE-RELATED CASES BY AGGRESSIVELY TARGETING DRUG SUPPLIERS WHO ARE DISTRIBUTING DEADLY NARCOTICS WITHIN THE COMMUNITY.
- THE OVERDOSE RESPONSE TEAM (ORT) INVESTIGATES SPECIFIC OVERDOSE-RELATED CASES THAT RESULT IN DEATH OR, IN SOME CASES, NEAR DEATH.
- ORT DOES NOT FOCUS ITS INVESTIGATIONS ON PERSONS WHO ARE USERS, OR ADDICTS.
- PROVIDE CLOSURE FOR FAMILIES AND PREVENT FURTHER LOSS OF LIFE.

Clark County District Attorneys Office

- Specific HIDTA Deputy District Attorneys are assigned to prosecute ORT cases.
- Every aspect of every case has a Deputy District Attorney involved.
- Specific guidelines set forth by the DA's Office will determine if a case will be prosecuted.



TEAM ACHIEVEMENTS

SUMMARY OF ARRESTS AND CHARGES

- Since it's inception, ORT has made 29 murder arrests.
  - All were drug traffickers, suppliers, and major distributors.
  - All ORT cases litigated have resulted in felony convictions.
- 2024 YTD
  - 11 murder arrests
  - 4 arrests were upgraded to 1st degree murder
  - 2 suspects charged federally

What we are seeing on scene

- More habitual users.
- Less young and naïve.
- More victims who thought they were using one specific type of drug which also contained fentanyl, causing death.
- More scenes with multiple people deceased from a fentanyl overdose.
- Pressed pills and powder are still the most common form of fentanyl.

Southern Nevada Post Overdose Response Team. (SPORT)

ORT Detectives and Officers have had limited access to resources to pass on to family, or friends of deceased loved ones and overdose survivors.

When the ORT team was stood up in 2019, the goal was to have a care element attached which has finally come to fruition.

The SNHD along with HIDTA have formed the Southern Nevada Post-Overdose Response Team (SPORT) initiative.

A partnership of public safety and public health.

This public health public safety initiative combines addressing drug trafficking through the criminal investigative approach to remove dangerous drug traffickers who are causing harm to citizens while simultaneously support the community's public health through an essential care program.

Questions

CAPTAIN MICHELLE TAVAREZ

Appendix N

Opioid Task Force Presentation

SPORT Overview

Presenters:

Treva Palmer
Senior Disease Investigator and Intervention Specialist

Elizabeth Adelman
Communicable Disease Supervisor

July 18th, 2024

- What is SPORT?
  - Southern Nevada Post-Overdose Response Team (SPORT)
  - Supported through the COSSUP (Comprehensive Opioid, Stimulant, and Substance Use Program) grant through the Bureau of Justice Assistance
  - The SPORT project gives us the opportunity to work with people who have just experienced an overdose.
    - More immediate intervention opportunities
    - Whole person-centered approach
    - Warm hand off to services

- How does the SPORT Team receive cases for follow up?
  - HIDTA (High Intensity Drug Trafficking Agency)
  - Self referred-dedicated SPORT email
  - EMS/law enforcement (in the future)

- Types of referrals:
  - Overdoses reported to ORT
  - Survivors of those who overdosed (may or may not also be using substances)
  - Self-referrals

- SPORT model
  - Connect with the client and consent to care.
  - Assess risk of future overdose.
  - Establish a follow up plan.

Considering Social Determinants of Health

- SNHD IS LEVERAGING THE CDC'S SOCIAL VULNERABILITY INDEX (SVI) TO ENHANCE OUR OVERDOSE RESPONSE FRAMEWORK IN CLARK COUNTY.
- BY INCORPORATING SVI DATA INTO OUR PROGRAM IMPLEMENTATION, WE WILL PROACTIVELY IDENTIFY VULNERABLE COMMUNITIES, TAILOR RESPONSE TIMELINES, AND ALLOCATE RESOURCES EFFECTIVELY TO ADDRESS EMERGING OVERDOSE TRENDS AND COMMUNITY NEEDS.

- When do we respond?
- SPORT Teams will have ability to respond 24/7
- Standby phone established to meet this expectation
- Response is based on an internal response protocol

Acknowledgements:

HIDTA's ORT Team

SNHD SPORT DIIS and leads

UNLV

Appendix O

IMPACT EXCHANGE

a 501c3 non-profit

Located at the corners of West Charleston and Jones Blvd

6114 W. Charleston Blvd

Las Vegas, Nevada 89146

Store Front Phone 702 840-6693

We do Harm Reduction

- **Harm reduction**, or **harm minimization**, refers to a range of intentional practices and public health policies designed to lessen the negative social and/or physical consequences associated with various human behaviors, both legal and illegal.[1] Harm reduction is used to decrease negative consequences of recreational drug use and sexual activity without requiring abstinence, recognizing that those unable or unwilling to stop can still make positive change to protect themselves and others

How ?

- Taking Impact Exchange services to persons – where they are at!
  - Physically
  - Emotionally
  - Drug(s) of choice
  - Needs
- Regardless of Gender, Age, Race, Orientation, Language, Appearance, Country of Origin, Smell, Housed or Out-n-About
- Five basic approaches to service(s) delivery

HOW - continued

1. Store front – daily hours – five days a week currently
2. Vending Machines – seven in Clark Co; five in Reno; one in rural
    - Six more machines coming online in Washoe – northern NV within 12 months
    - Six to eight machines coming online in Clark Co – including rural areas
3. Outreach – Static sites using same location place, time, day of week or month offering same types of products and services
4. Outreach – Fluid site visitation dependent on movement of participants within community for delivery of same service as static (if possible – testing?)
5. Mail delivery – though out Nevada including Clark Co., Rural, Washoe Co., and Carson City

WHY?

- To interact with participants in a consistent manner that –
  - Builds trust
  - Builds relationships
  - Builds support systems
  - Acts as a conduit to services
  - Allows for narrowcasting of messages and news
    - New services within community
    - News about drugs within the community – bad, good, whatever
  - Allows awareness of hosting agencies: the type of agency, services offered, and staff that provide when utilizing vending

Why-continued

- Distribution of products that bring the participant back into contact with services of Impact Exchange approximately every week
  - 40 syringes might hold a participant for eight days – maybe more or less
  - Vending offering the support if less or lack of mobility to reach store front or outreach
  - Outreach offers the third leg for participants requiring services sooner
- Distribution has an added component – gives participant exposure to services and staff of **“hosting agency”** basic free advertising

Why - vending

- Vending machines
- don’t -- Discriminate or Judge
- Allow --
  - participant freedom of choice
  - participants to not engage in discussions about what they are seeking –
    - *“could I have the extra large, non lubricated, ribbed, black, single pack condoms and five extra packages of lubricant”?*
    - *“could I get two of the pregnancy test and condom kits”?*
- *offer privacy and access –*
  - *without the cost of staff to engage with a person not seeking human contact*

Structure - storefronts

- Three store fronts at Charleston and Jones
  - 6114 W. Charleston Blvd -- Storefront for participants to obtain
    - Supplies and SSP syringe disposal drop off
    - HIV testing/referral/information
    - Hepatitis testing/referral/information
    - Wound care referral to Trac-B Exchange Care and Education unit
    - Syringe and sharps processing and disposal
    - Test strips for individual participant drug testing
    - Drug testing of used syringes and actual products/containers
    - Narcan and Naloxone

Structure - storefronts

- Three store fronts at Charleston and Jones
  - 6108 W. Charleston Blvd -- Care n Education Unit
    - Hygiene education
    - Wound care – Impact Exchange Nurse Practitioner
    - Access to care and pharmacy partners onsite
    - Additional drug testing site
  - 6106 W. Charleston Blvd – Community Room
    - Participant meeting area
    - Group project / education area
    - Supplies of food, clothing, and other need items

Structure-warehouse

- Four warehouse units for supplies, product production, and vending program
  - SSP Syringe and sharps container supply for entire State of Nevada
  - Inventory of items to contain supplies for distribution – plastic/paper bags; boxes; pouches; mailers; etc.
  - Vending machine repair and storage prior to location placement
  - Mailing and shipping service site/office
  - Transport services (Shipping and Delivery)
  - Staffing, meeting and space for Board as needed

Structure warehouse - continued

- Production of various kits – to include but not limited to:
- Syringe kits (40 count);
- Firstaid (various types);
- Hygiene kits (from bare minimum to weekly item quantities);
- Drug testing kits
  - Simple single strip packets
  - Multi drug test strip packets
  - Total kit type - multi drug test strip kits (strips, sterile water, testing caps (plastic), disposal packaging
- Narcan and Naloxone-(injection) kits for store front, outreach, vending
- Hormone injection kits
- Condom packaging for distribution through storefront, vending, outreach
- Other products – pregnancy test kits, hydration and nutrition, services info

Who am I

- Rick R Reich
- Executive Director
- rick@tracbexchange.com
- 702 960 2909

Thank you for your time today

Appendix P

Opioid Misuse Prevention

in Clark County, NV

www.drugfreelasvegas.org

Presented by Ayla Babakitis,
PACT Coalition Manager

PACT COALITION
PREVENTION, ADVOCACY, CHOICES, TEAMWORK

PACT Coalition for Safe and Drug Free Communities

Mission : Empower Southern Nevada with the resources to prevent substance misuse for all ages and promote recovery through culturally competent advocacy, education, stigma reduction, support, and outreach.

01.

Neutral Convening Table

PACT Coalition works to strengthen communities by acting as a neutral convening table and bringing together key stakeholders and decision-makers to address emergent issues and bring about systemic change

02.

Education and Training

As a community agency, PACT provides education and outreach opportunities for the betterment of Clark County.

03.

Pass-Through Agency

PACT also acts as a pass-through agency for large state and federal grants, administering sub-awards to local agencies to provide direct, evidence-based prevention programming.

The more effective the primary prevention strategies, the less need there are for secondary and tertiary prevention.

Primary Prevention

FIRST USE

The aim of primary prevention is to prevent use and abuse of alcohol, tobacco and other drugs before the behavior occurs.

- Establish resiliency in Youth through Protective Factors
- Reduce exposures to risk factors
- Changing the environment to reduce access

Secondary Prevention

MISUSE

The aim of secondary prevention is to reduce the impact of a problem that has already occurred.

- Diversion programs
- Supportive workplace recovery
- Trauma Informed Care

Tertiary Prevention

OVERDOSE/HARMS

The aim of tertiary prevention is to soften the impact of ongoing problems.

- Naloxone or Fentanyl Test Strips
- Good Samaritan Law
- Education on safer use practices

Source: https://nam.edu/primary-secondary-and-tertiary-prevention-of-substance-use-disorders-through-socioecological-strategies/

Opioid Misuse Prevention

Pain Management

Over utilizing opioids for pain management and no education/resources on alternatives.

Recommendation:

- Increase education on pain management alternatives
- Reduce prescribing rates

Medication Management

Ease of access to prescriptions from individuals in the households (not locked away and keeping unused medication for future use)

Recommendation:

- Promote Pill Take Back Day and educate on safe medication management practices
- Medication adherence monitoring

Self Medicating

Individual lack of education and coping skills that results in misuse.

Recommendation:

- Increase education on healthy coping mechanisms
- Reduce prescribing amounts

100 Cups of Coffee Project

What do you believe are barriers to people receiving or carrying Narcan?

58 **Lack of knowledge:** On what the products are, where to obtain it (and for free), its importance, how to use it.

34 **Availability Issues:** Hard to find it, lack of up to date resource lists, not easily accessible in each zipcode, not knowing where to obtain, hard to carry, not enough supplies.

31 **Stigma:** Seen as enabling, afraid to interact with someone experiencing an overdose, not wanting to carry out of association with drug use, fear of judgement, fear of being tracked.

“People don’t know enough about Good Samaritan Law and knowledge of distribution sites, people aren’t aware of the level of the problem and believe "not in their community".”

“They are scared that they will get in trouble with law enforcement. Some may also be intimidated about carrying and administering the Narcan to someone.”

100 Cups of Coffee Project

Now that more people are aware of and have access to harm reduction supplies such as Narcan and Fentanyl Test Strips, what are some factors contributing to overdose deaths not being dramatically reduced?

“Some don’t care about using the HR supplies and also some don't care what is in their substances. They don’t believe an overdose would happen to them.”

45 **Lack of Concern:** Not in a state of mind to use it, not thinking their drugs are laced, dont think it'll happen to them, more focused on the high than preventing overdose, using more drugs since they feel safe to get pulled out of an overdose

28 **Lack of Knowledge:** Not knowing supplies exist or where to get it, marketing isnt widespread, not aware of fentanyl danger

27 **Potency:** Substances nowadays are stronger, “casual” users unaware of potency/dangers, there’s no standard dose of Narcan, some people are seeking it intentionally or will still use since they bought the drug

24 **Accessibility:** Users are not with sober people, people dont want to carry it on them (bulky), not easily accessible, people wont go out of their way to get it

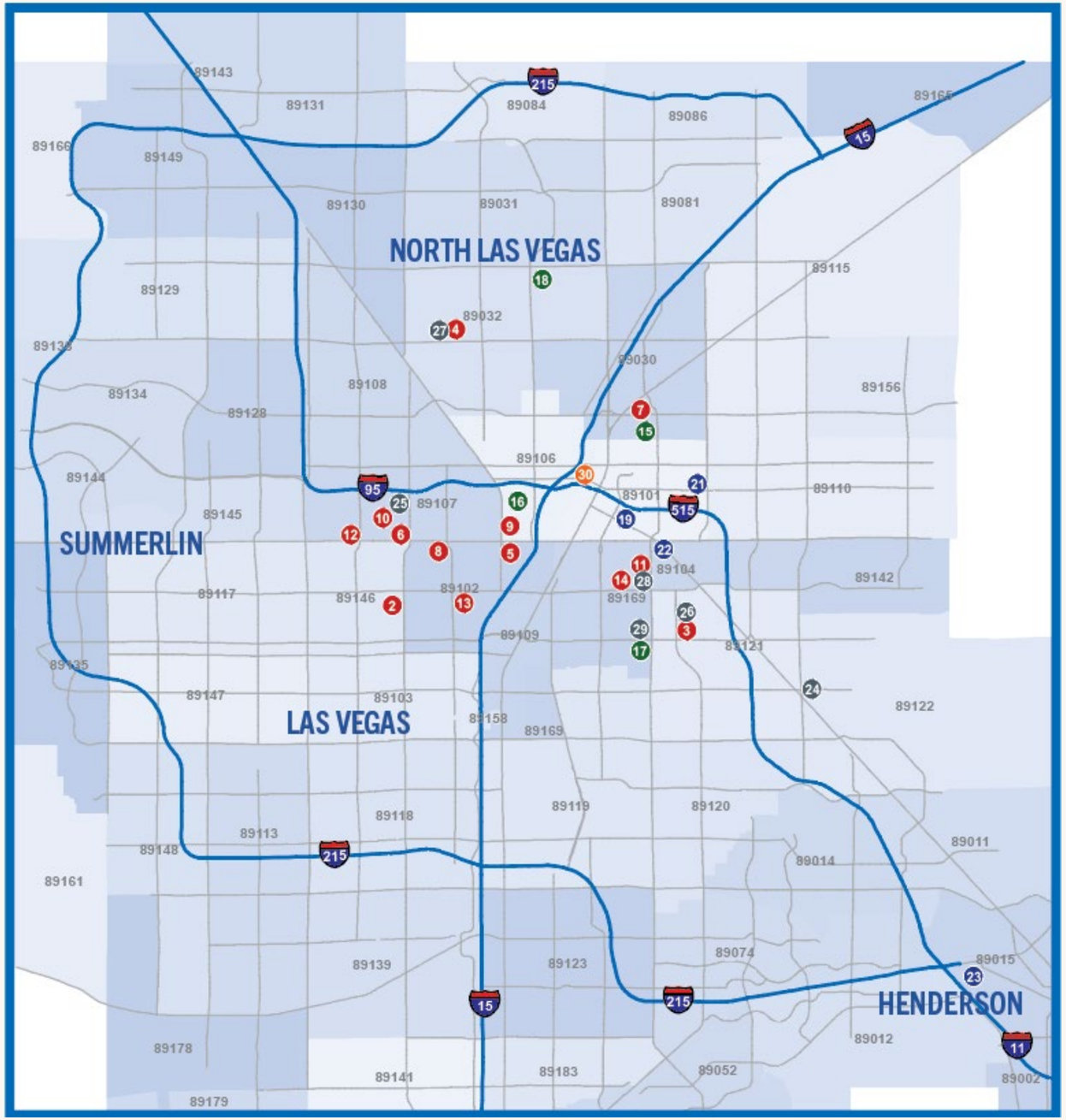
100 Cups of Coffee Project

On a scale of 1 to 10, how important do you believe it is for communities to address and respond to the impact of Adverse Childhood Experiences (ACEs)?

80 *people rated ACEs as the most important thing for communities to address.*

92 *Rated ACE's 8 or higher in importance for community to address*

"Trauma plays a significant role in coping and can lead to using substances to ease pain and stress."



Harm Reduction Distribution Sites

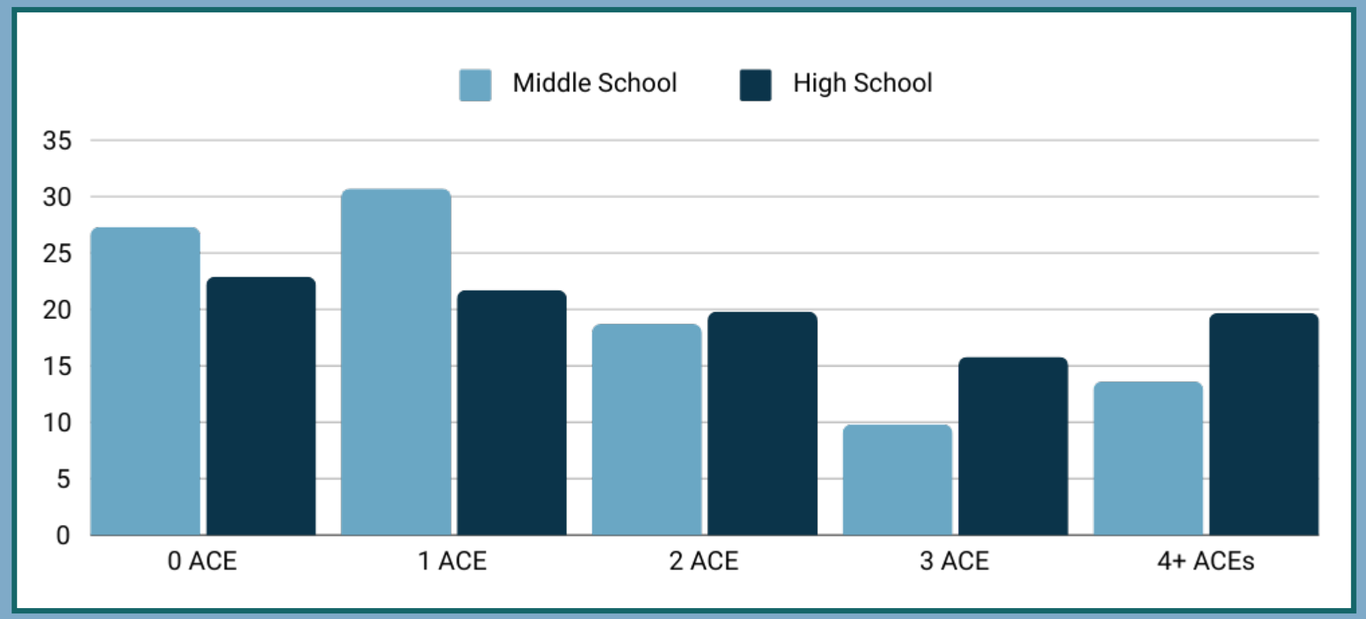
*** Data collected as of March 2024 as part of the 2024 Comprehensive Community Prevention Plan

Mesquite, NV

Boulder City, NV

Adverse Childhood Experiences

Potentially traumatic events that can happen to children between the ages of 0 and 17. ACEs can have long-term effects on a person's health, well-being, and opportunities



*2023 Data

People with 1 or 2 ACEs are:

- **2x** more likely to have serious financial problems
- **2.5x** more likely to smoke
- **2.6x** more likely to develop pulmonary disease
- **3x** more likely to have serious job problems
- **3x** more likely to use antidepressants
- **4x** more likely to develop STDs

People with 4 or more ACEs are:

- **12x** more at risk for suicide
- **7x** more likely to develop alcoholism
- **4x** more likely to develop depression
- **2-4x** higher risk of using alcohol or other drugs
- **2-4x** more likely to begin substance use at a young age
- **2x** higher rate of heart disease or lung cancer

Trauma-Informed Care

Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness.

Safety

Trustworthiness + Transparency

Peer Support

Collaboration

Empowerment

Humility + Responsiveness

Recommendations

01.

Increase distribution sites and community knowledge of supplies and how to use them.

02.

Increase prescription education (alternatives, disposal methods, medication mangement).

03.

Increase resiliency and coping mechanisms for mental and physical wellness to deter reliance on substances for pain relief.

PACT COALITION
PREVENTION, ADVOCACY, CHOICES, TEAMWORK

Thank you very much!

Ayla Babakitis, PACT Coalition Manager
ababakitis@drugfreelasvegas.org

Appendix Q

togetherforbetter

OPIOID DEATH REVIEW

09.19.2024

Melanie Rouse, Clark County Office of the Coroner / Medical Examiner

Brandon Delise, Southern Nevada Health District

Assembly Bill 132

- **After reviewing data pursuant to subsection 2, the Task Force may elect to conduct:**
- (a)A systemic review of opioid overdose fatalities occurring on or after October 1, 2023, as necessary to determine the responsiveness of community services; or
- (b)A review of opioid overdose fatalities in the zip codes of Clark County with the highest numbers of opioid overdose fatalities.

Volume of Cases Summary

- From October 1, 2023 to August 1, 2024
- Looking at closed cases only
- >600 opiate related fatalities
- Performance of an in-depth review requires us to narrow the scope
- Based on the categories agreed upon by CCOCME and SNHD a thorough review of 15 cases was completed

Review

Category #1: ZIP Codes With Highest Crude Opioid Overdose Death Rates

Top Resident ZIP Codes with the Highest Crude Opioid Overdose Death Rate per 100,000 Clark County Residents, 10/2023-08/2024			
ZIP	Count of Deaths	Population	Rate per 100,000
89101	32	41479	77.147
89104	21	36516	57.509
89106	12	30811	38.947
89119	15	47594	31.517
89121	19	67609	28.103
89103	12	45170	26.566
89011	11	41693	26.383
89123	13	58026	22.404
89115	13	73305	17.734

Category #2: Groups with a 50% or Greater Increase in Deaths: Oct 2023 - Aug 2024 vs. Oct 2022 - Aug 2023.

Drug Overdose Death Comparisons

Date	All Opioid			Fentanyl			Meth + Fentanyl		
Age	10/2023-08/2024	10/2022-08/2023	% Change	10/2023-08/2024	10/2022-08/2023	% Change	10/2023-08/2024	10/2022-08/2023	% Change
Under 1 year	0	-	-	0	-	-	0	0	0
1 to 4 years	-	-	-	-	-	-	0	0	0
5 to 9 years	-	0	-	-	0	-	0	0	0
10 to 14 years	0	0	0	0	0	0	0	0	0
15 to 19 years	-	6	-	-	-	-	-	-	-
20 to 24 years	11	19	-42.11	9	18	-50	-	5	-
25 to 29 years	45	33	36.36	41	33	24.24	21	12	75
30 to 34 years	74	50	48	71	40	77.5	38	16	137.50
35 to 39 years	49	62	-20.97	47	48	-2.08	32	27	18.52
40 to 44 years	43	39	10.26	37	32	15.63	21	11	90.91
45 to 49 years	36	36	0	33	22	50	16	14	14.29
50 to 54 years	36	30	20	28	23	21.74	16	17	-5.88
55 to 59 years	25	23	8.70	20	16	25	8	6	33.33
60 to 64 years	25	25	0	15	14	7.14	10	9	11.11
65 to 69 years	19	24	-20.83	14	14	0	-	6	-
70 to 74 years	5	5	0	-	-	-	-	-	-
75 to 79 years	-	-	-	-	-	-	0	0	0
80 to 84 years	-	-	-	0	-	-	0	0	0
85 years and over	0	0	0	0	0	0	0	0	0
Race									
Hispanic	90	78	15.38	84	67	25.37	38	30	26.67
Black	67	51	31.37	62	42	47.62	30	18	66.67
AI/AN	-	-	-	-	-	-	-	-	-
Asian/PI	7	-	-	6	-	-	-	-	-
White/Caucasian	192	214	-10.28	151	148	2.03	90	69	30.43
Other	5	-	-	-	-	-	-	-	-
Multi-racial	11	7	57.14	10	6	66.67	-	-	-
Gender									
Female	101	100	1.00	81	62	30.65	44	26	69.23
Male	275	260	5.77	240	210	14.29	127	99	28.28

Legend	
	>=50% Decrease
	50-100% Increase
	>=100% Increase

Category #3: Emerging Drug-Related Fatalities

Smoking Fentanyl:

Drug and Alcohol Dependence: Transition from injecting opioids to smoking fentanyl in San Francisco, California

Human Organization: Fentanyl smoking in San Francisco: Early signs of a new connoisseurship

National Library of Medicine: Changes in injecting versus smoking heroin, fentanyl, and methamphetamine among people who inject drugs in San Diego, California, 2020 to 2023

MMWR: Routes of Drug Use Among Drug Overdose Deaths — United States, 2020–2022

Novel Substances:

- Drug overdose deaths involving xylazine among Clark County residents have risen from 1 death in 2020 to 5 deaths in 2024.
- Drug overdose deaths involving carfentanil among Clark County residents have risen from 0 deaths in 2020 to10 deaths in 2024.

Categories Of Cases Reviewed

Category #1: ZIP Codes with the Highest Crude Opioid Overdose Death Rates

- **ZIP Codes**
  - 89101
  - 89104
  - 89106
  - 89119
  - 89121
  - 89103
  - 89011
  - 89123
  - 89115

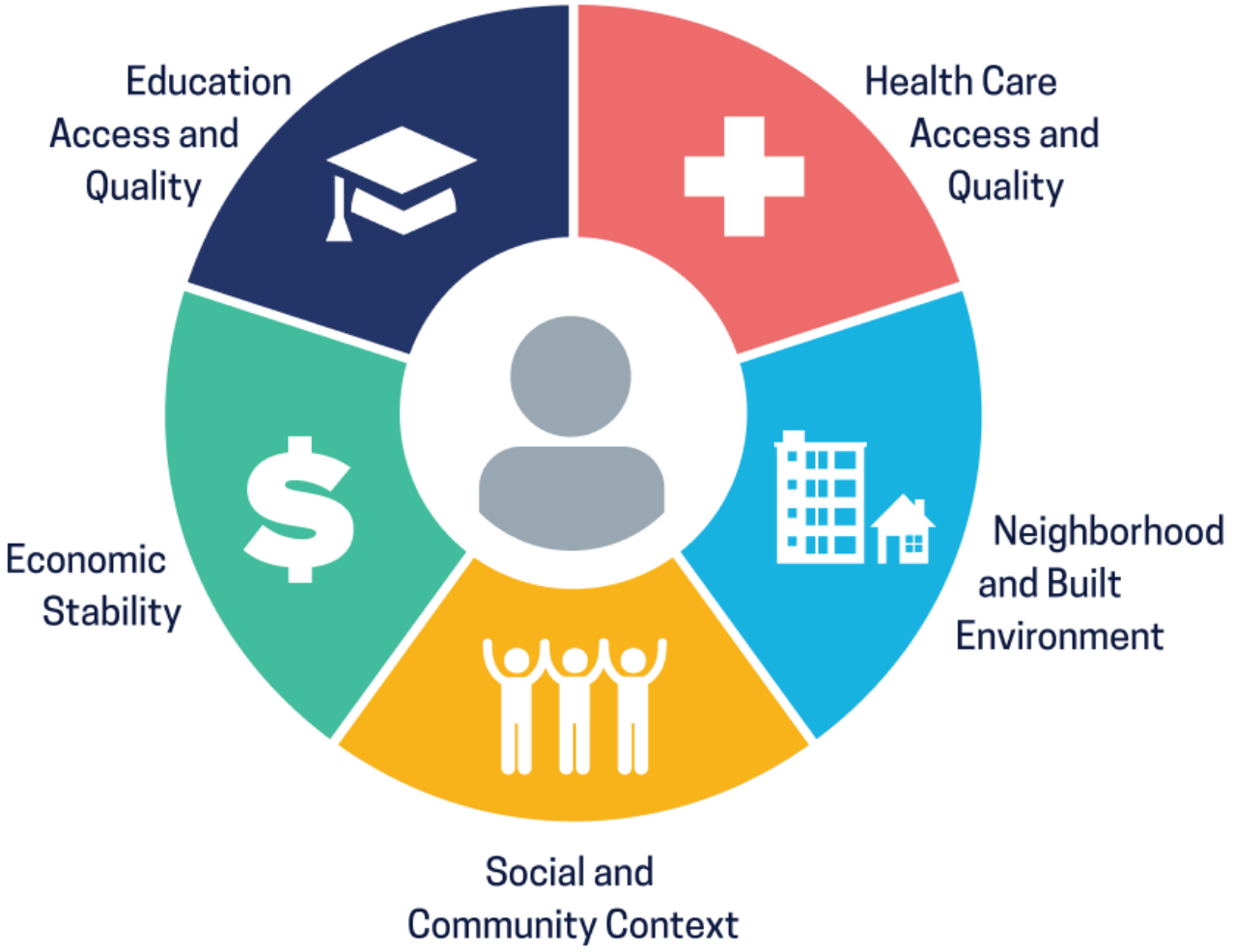
Category #2: Groups with Marked Increase in Deaths

- **Fentanyl Deaths**
  - 30–34-Year-olds
  - 45–49-Year-olds
- **Meth & Fentanyl Deaths**
  - 30–34-Year-olds
  - 40–44-Year-olds

Category #3: Emerging Drug-Related Fatalities

- **Smoking Fentanyl**
- **Novel Substances**

CDC:
Social Determinant of Health



Categories for Data Calculation

- Hx recurrent hospitalizations
- Hospitalizations with c/o pain
- Hospitalizations w/o UDS
- Issuance of Narcotics w/o drug screen
- Hx past OD
- Hx of Receiving Narcan
- Hx Mental Illness
- L2K hold
- Hx of arrests, jail, incarceration
- Hx of outpatient treatment
- Hx of inpatient treatment
- Hx of admission to substance abuse
- Hx ETOH use
- Hx of smoking/vape
- Hx job loss
- Hx unemployment
- Hx of being unhoused
- Hx of lacking permanent housing
- PMP

	Percentage with Risk Factor Methamphetamine and Fentanyl	Percentage with Risk Factor Fentanyl	Percentage with Risk Factor Smoking Fentanyl	Percentage with Risk Factor Novel Substances	Total Percentages Across all Groups
Hx recurrent hospitalizations	50.0%	100.0%	66.7%	66.7%	66.7%
Hospitalizations with c/o pain	83.3%	100.0%	66.7%	33.3%	73.3%
Hospitalizations w/o UDS	66.7%	66.7%	66.7%	33.3%	60.0%
Issuance of Narcotics w/o drug screen	66.7%	33.3%	33.3%	33.3%	46.7%
Hx past OD	50.0%	33.3%	66.7%	33.3%	46.7%
Hx of Receiving Narcan	50.0%	33.3%	66.7%	33.3%	46.7%
Hx Mental Illness	83.3%	100.0%	66.7%	0.0%	66.7%
L2K hold	33.3%	33.3%	66.7%	0.0%	33.3%
Hx of outpatient treatment	50.0%	33.3%	66.7%	33.3%	46.7%
Hx of inpatient treatment	16.7%	33.3%	66.7%	0.0%	26.7%
Hx of arrests, jail, incarceration	50.0%	66.7%	33.3%	0.0%	40.0%
Hx of admission to substance abuse	83.3%	100.0%	100.0%	100.0%	93.3%
Hx ETOH use	16.7%	33.3%	66.7%	66.7%	40.0%
Hx of smoking/vape	50.0%	33.3%	66.7%	33.3%	46.7%
Hx job loss	16.7%	33.3%	33.3%	0.0%	20.0%
Hx unemployment	83.3%	66.7%	100.0%	66.7%	80.0%
Hx of being unhoused	50.0%	33.3%	66.7%	66.7%	53.3%
Hx of lacking permanent housing	66.7%	33.3%	66.7%	66.7%	60.0%
PMP	83.3%	66.7%	100.0%	66.7%	80.0%

Key Highlights

- “Smoking the French Oil”
- Average and Above Average PMP reports
  - Noted 2 year limitation on PMP
- Positive UDS screens
- Lack of UDS screens
- Admission to Drug Abuse
- Unemployment
- Hospitalizations with c/o pain

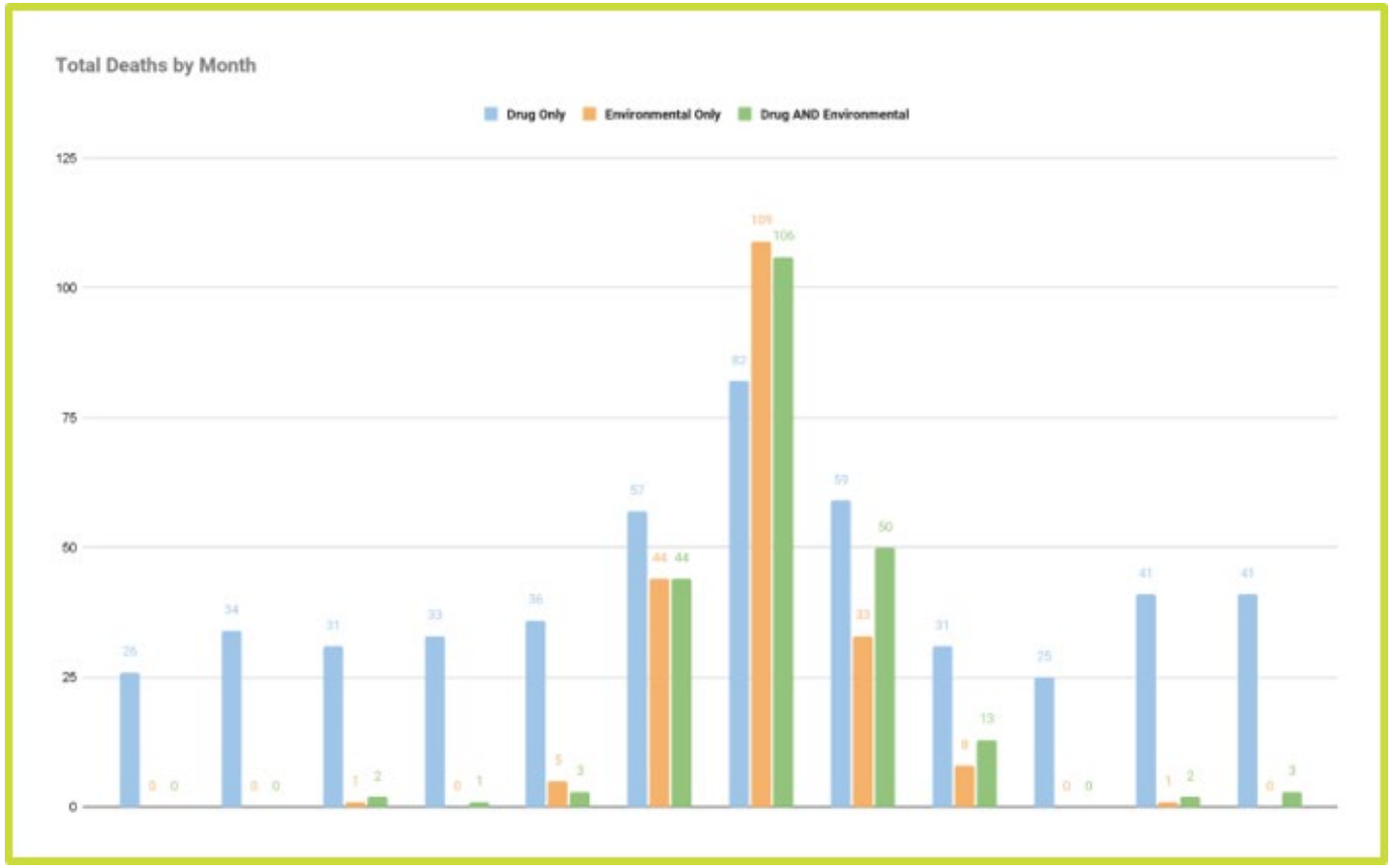
Additional Factors for Consideration

- Heat Related Fatalities and Drug Deaths
- Study by PHD candidates and ME
  - Liam J. Johnson, Katherine Gaddis, Lisa Gavin

Why is this Relevant?

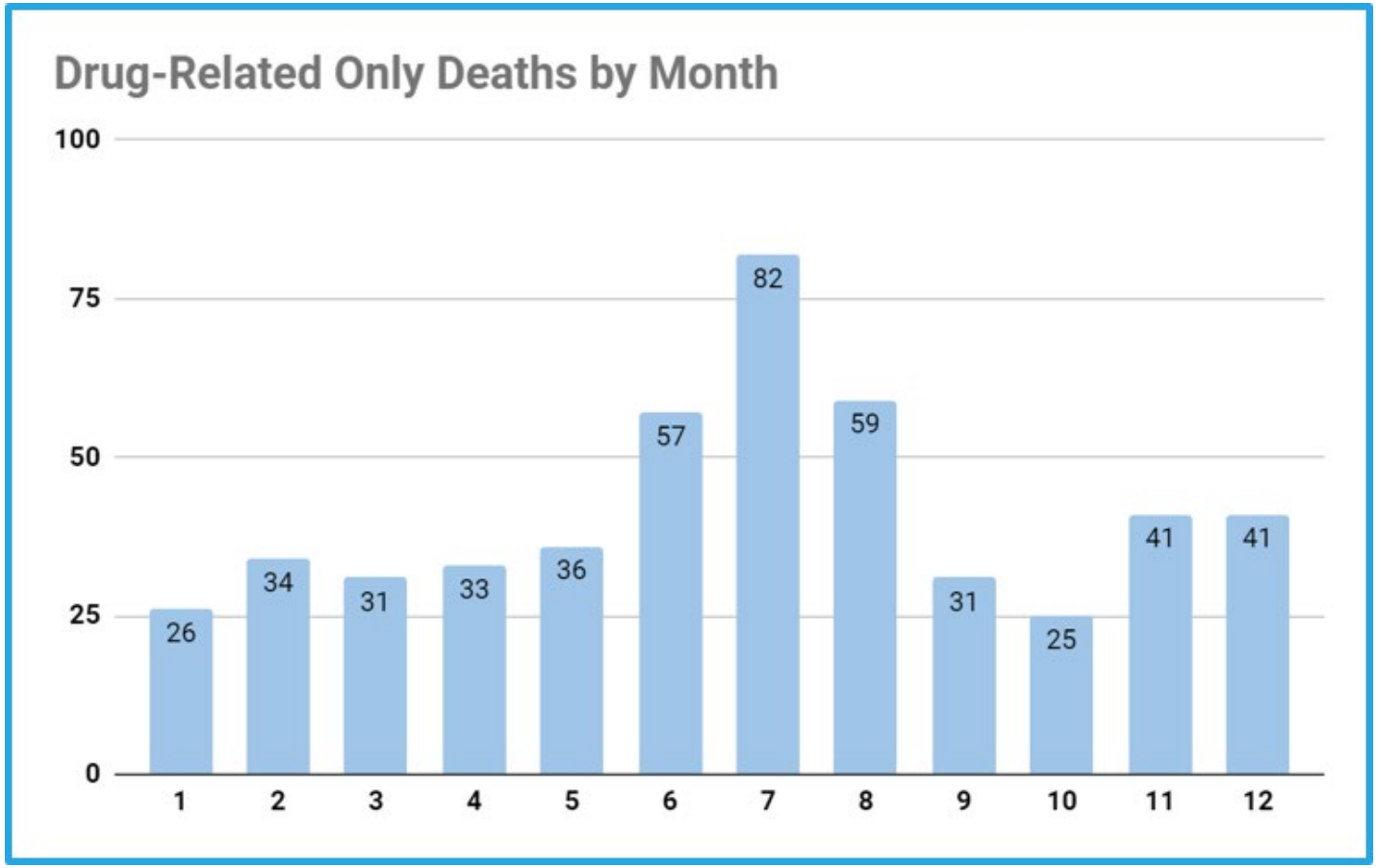
- Thermoregulation
  - Stimulants impact the ability to thermoregulate
  - Causes hyperthermia

Environmental Exposures and Drug-Related Deaths



Drug Category	Heat	Cold	Unknown
Cocaine	7	0	0
Fentanyl	1	0	0
Methamphetamine	204	7	1
Methamphetamine and Cocaine	3	0	0
Methamphetamine and Fentanyl	1	0	0
Fentanyl and Cocaine	0	0	0
Methamphetamine, Fentanyl, and Cocaine	1	0	0
Other Drugs	0	0	0
Total	**225**		

Drug Related Deaths by Month



Drug Category	Totals
Methamphetamine Only	335
Fentanyl Only	9
Cocaine Only	41
Methamphetamine and Fentanyl	38
Methamphetamine and Cocaine	12
Fentanyl and Cocaine	1
All Drugs	1
Other Drugs Only	59
Total	**496**

References

- Clark County Office of the Coroner/Medical Examiner. (n.d.). *Moon client*. Moon Client. https://clark.vertiq.us/

- Johnson, L. Gaddis, K. Gavin, L. (2024). Heatwaves and Health: Exploring thermoregulation and mortality risks among the unhoused.

Appendix R

togetherforbetter

Clark County Regional Opioid Task Force

Overview of Presentations Received

Overview of AB132 Requirements

- Review data relating to opioid overdose fatalities and near fatalities in the county to identify gaps in community services relating to opioids and opioid overdose fatalities.

- Conduct a review of opioid overdose fatalities on or after October 1, 2023 to determine responsiveness of community services or review of opioid overdose fatalities in the zip codes of Clark County with the highest numbers of opioid overdose fatalities.

- Identify trends in social determinants of health relating to opioid overdose and opportunities for collaboration to leverage existing resources to prevent opioid overdose fatalities, prevent substance misuse and promote recovery for persons with addictive disorders.

Gaps

- Lack of funding
- Limited services and resources
- Lack of available data
- Workforce challenges

Social Determinants of Health

- Unequal access to treatment
- Transportation
- Lower income, housing vouchers and housing assistance for at risk population
- Stigma

Opportunities for Collaboration

- Data collection
- Data sharing
- Agency partnerships

Recommendations

- Increase funding
- More real time data gathering and sharing
- Increase preventative measures
- Increase services and service areas
- Community education on Narcan training and harm reduction
- Overdose fatality review teams

togetherforbetter

Presentations

3/14/2024

- Office of Analytics
- Substance Use Response Group (SURG)

4/18/2024

- Clark County Coroner's Office
- Southern Nevada Health District
- Southern Nevada Opioid Advisory Council (SNOAC)
- Fentanyl Awareness Campaign (City of Henderson)

7/18/2024

- Tina
- Nevada Opioid Treatment Association (NOTA)
- Crossroads of Nevada
- Bridge Counseling
- Clark County Fire Department
- Las Vegas Metropolitan Police Department Overdose Response Team
- The Southern Nevada Post Response Team (SPORT)

Resources

- Handout with follow up questions, answers and referenced documents.
  - Substance Use Response Working Group (SURG)
    - RxStat
  - Office of Analytics
    - Nevada Opioid Needs Assessment and Statewide Plan 2022
- Clark County Regional Opioid Task Force Webpage at https://www.clarkcountynv.gov/government/departments/opioid_task_force/index.php
  - AB132
  - Presentations and recorded meetings
- Please reach out to Sue or Ariana if you have any questions.

Responses from Office of Analytics (Kyra Morgan and Natalie Bladis)

Clark County Regional Opioid Task Force, March 14, 2024 Follow up Questions

1. What gaps have you identified in community services related to opioids and opioids overdose fatalities?

Gaps in Primary Prevention

- Community-based prevention programs across all counties, especially for families and youth
- Full implementation of the Zero Suicide Initiative
- School-based prevention programs with measured outcomes that are implemented statewide and are culturally sensitive
- Prescription drug disposal programs
- Patient education on the addictive potential of opioids, and alternative therapies for chronic pain and chronic illness
- Education among high school students around SUDs, awareness of the opioid epidemic, and naloxone use, and attitudes about discussing these topics with health care providers
- Anxiety over seeking help, especially among veterans and tribal members
- Homeless encampment outreach
- Collaborative practice agreements and communication between prescribing providers
- Culturally competent and culturally centered prevention efforts targeted at underserved populations

Gaps in Provider Education

- Education and monitoring with additional metrics and demographic information
- Participation in Project ECHO
- Education of patients on pain management expectations
- Utilization of/referrals to other pain management options
- Pre-treatment screening and care plans that include alternative pain management
- Insufficient screening for SUDs, especially in Medicaid managed care and in rural areas

Gaps in Secondary Prevention

- Broad adoption and implementation of SBIRT models, including in primary care and other community-based health care settings
- School-based secondary prevention
- Trainings for people and their family members who use or misuse opioids and/or have experienced a nonfatal overdose, including overdose prevention and reversal strategies
- Programs to decrease stigma among medical providers
- Programs to decrease stigma among community members likely to interact with people in recovery
- Statewide programs to address stigma in the public
- Education on treatment options for OUDs
- Education for family members on treatment of OUDs

Gaps in Tertiary Prevention and Harm Reduction

- Limited hours of operation for harm reduction services
- Community education for the use of Naloxone
- Education on harm reduction resources and methods in rural areas
- Privacy from the public and from law enforcement when using harm reduction resources, especially in rural areas

- Education in encampment communities
- Needle exchange capacity is low relative to need in all regions of the state
- Prohibitive prior authorization requirements for peer recovery support services

Gaps in Outpatient Treatment

- Data on equity and disparities in treatment outcomes for racial and ethnic minorities • Provider availability for pregnant women with OUD
- Treatment/provider availability for individuals with co-occurring disorders, especially youth, and serving youth in inpatient and residential facilities
- Access to mental health care as compared with disease prevalence and demand for treatment
- Residential and outpatient MAT programs in rural and frontier areas
- Transportation to treatment and recovery supports, especially in rural and frontier areas and for non-Medicaid populations
- Withdrawal management services with seamless transfer to treatment after detoxification
- Utilization of existing OTPs to capacity
- Availability of OTPs in most counties
- OBOT in rural and frontier areas
- Counseling for individuals receiving OBOT
- Psychiatrists and psychologists specializing in SUD psychotherapy
- Outpatient detoxification and licensed drug and alcohol counselors in rural regions
- MAT and other treatment interventions in justice facilities
- Evidence-based treatment protocols for those using multiple substances and for those with co-occurring mental health and physical health disorders

Gaps in Inpatient, Residential, and Detoxification/Withdrawal

- Short- and long-term rehabilitation in all regions of the state
- Funding for withdrawal and residential treatment beds for Medicaid beneficiaries (ages 22 years–64 years) and the uninsured
- Supports for people who have completed detoxification but are awaiting treatment
- Short-term rehabilitation (< 30 days) and long-term rehabilitation (30+ days) statewide
- Access to inpatient, residential, and withdrawal management services in rural areas
- Funding for infrastructure to expand withdrawal and other levels of care

Gaps in Crisis Services

- Statewide, consistent and coordinated, in-person, 24/7 mobile crisis response system
- Single point of contact for behavioral health crises
- Dispatch independent mobile crisis teams through central crisis call center
- Mobile crisis teams that are trained in harm reduction and carry naloxone
- CSUs, especially accessible to rural and frontier areas
- Staffing for crisis system

Gaps in Treatment in the Criminal Justice System

- Post-release bridging services to offer engagement during incarceration and transitional support into the community
- Knowledge base of probation/parole offices on the needs of individuals on release/community reentry regarding treatment support options and harm reduction
- Statewide availability of drug courts and transitional/reentry services and supports ranging from treatment to housing
- Public support for treatment and prevention services for individuals re-integrating into the community post-incarceration
- Access to MAT and other treatment interventions within the jails and prisons

Gaps in Recovery Support

- Access to desired peer supports for pregnant and postpartum women
- Statewide availability of peer supports throughout the treatment and recovery system

Gaps in SDOH

- Lower income and higher unemployment and poverty for those living on tribal lands
- Housing vouchers and housing assistance for at-risk populations (especially Northern and Southern regions and Clark and Washoe Counties)
- Transportation for both treatment and recovery support activities
- Employment for those receiving treatment
- Volunteer and vocational opportunities for those in recovery
- Internet access for people engaging in treatment
- Financial resources for people in treatment and recovery

2. What recommendations do you have to address the gaps you've identified?

Recommendations can be found on page 83, Section 6 of the Opioid Needs Assessment and Statewide Plan . These are further broken down in the Statewide Opioid Plan (Section 7, page 115) into goals, strategies, objectives and activities.

3. If you were tasked with this responsibility, what would your first initiatives be?

Some of our first initiatives have been to build capacity focusing on evidence based practices, MOUD treatment in carceral facilities, youth prevention/treatment, transitional housing, and harm reduction.

4. How can we improve data collection and reporting systems to better monitor and track opioid overdose deaths?

Recommendations for improving data collection and reporting systems can be found on page 85, Section 6 of the Opioid Needs Assessment and Statewide Plan. The recommendations are summarized below:

- Establish Nevada all-payer claims database (APCD). The State is currently making progress on this recommendation. The database is intended to and should include claims for all medical, dental, and pharmacy benefits. The advisory committee that will make recommendations on the analysis and reporting of the data should ensure that key data elements are maintained through

the de-identification process to ensure the data remain meaningful. Critical needs include the ability to stratify by special population characteristics (race/ethnicity, geography, LGBTQ+ status, pregnancy, etc.), and enough detail to identify physical and behavioral health comorbidities.

- Develop an overdose fatality review committee(s).
- Support the Automated Program Interface (API) connection to EMS/Image Trend for data collection and reporting through the overdose mapping and application program (ODMAP).
- Support Poison Control hotline and data collection/reporting to track and trend; establish a communications system and dashboard.
- Expand reporting to the prescription drug-monitoring program to include methadone to increase patient safety and reduce prescribing risk.
- Share standardized data between public safety agencies and those monitoring local overdose spike response plans. This will support local partners so they may act quickly when needed.
- Evaluate the outcomes from the Association of State and Territorial Health Officials Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative and State Opioid Response grant projects for pregnant and postpartum women and their infants, and implement lessons learned. Ensure that outcome data is detailed and stratified by important demographic characteristics in order to detect and address health disparities. Review of the outcomes from these projects will allow Nevada to analyze lessons learned and apply successes for future initiatives addressing SUD in additional identified special populations.
- Establish a minimum data set for suspected opioid use and overdose death data collection to standardize data across the state and better prevent overdoses. The NV -OD2A program has identified a minimum data set from law enforcement and other first responder agencies. The minimum data set relates to indicators that law enforcement agencies can collect and report on, although at the time the report was written , none were using the full minimum data points.
- Improve and standardize forensic toxicology testing and data. There are additional ways the State could get toxicology information to inform public health and public safety agencies about what is in the drug supply and what the potential risk for an overdose may be. These Data methods include testing of seized drugs through a lab or by field test, testing of syringes, wastewater testing, and urinalysis of people who have experienced a nonfatal overdose.
- Develop data tools to collect and report racial, ethnic, housing status, sexual orientation, and gender identity across datasets.
- Develop a statewide forensic toxicology lab that can support surveillance sample testing and other types of toxicology testing that Data may increase the amount of information used to inform community awareness of overdose risk, including substances involved in suicides.
- Increase data sharing using the HIE. Promote the use of HealtHIE Nevada chart provider portal at no cost to providers. Funding should be provided to providers in need of system updates or changes to Data allow for participation. This will increase the ability to share data across behavioral and physical health providers.
- Develop and maintain consistent query code and query logic for reporting on standard metrics across agencies to facilitate consistent reporting and monitoring of priority indicators related to the opioid Data epidemic. Develop and maintain a consistent timeline for when metrics should be run and reported. Develop a standard process for quality control and consistencies, as well as reporting caveats.
- Increase reporting of Treatment Episode Data Set (TEDS) for all Data certified providers.

- Increase availability and access to real-time substance use disorder (SUD) and opioid use disorder (OUD) reports. The State of Nevada has multiple sources that could provide real-time data. The health Data information exchange (HIE), electronic health record (EHR) systems, birth registries, the Prescription Drug Monitoring Program (PDMP), and OpenBeds should be evaluated for interoperability-based use cases that will provide the needed data for analysis. Non-claims-based data sources should also be utilized to ensure the capture of all necessary data.
- Partner with local coroner/medical examiner, medical schools, and other relevant stakeholders to develop an accredited forensic pathology program.
- Expand surveillance testing. This will require a new funding formula for forensic toxicology, as well as better leveraging of federal funds.

5. What are the key risk factors (e.g., social determinants of health) associated with an increased risk of opioid overdose fatalities?

Key risk factors associated with an increased risk of opioid overdose fatalities include:

- **Economic Instability:** Unemployment, poverty, and housing instability are significant risk factors. Economic hardship can lead to increased stress, reduced access to healthcare services, including substance use treatment, and greater engagement in risky drug-use behaviors (Galea, S., et al., 2021).
- **Access to Healthcare Services:** Limited access to healthcare services, including mental health and substance use treatment programs, is a critical risk factor. Individuals without adequate healthcare coverage may not receive necessary treatment for substance use disorders or chronic pain, increasing the risk of overdose (Tsai, J., et al., 2020).
- **Social Environment and Support Networks:** Social isolation, lack of social support, and community-level drug availability are important determinants. Areas with high rates of drug trafficking and availability often see higher overdose rates. Additionally, individuals who lack supportive networks are at greater risk (Hadland, S. E., et al., 2018).
- **Mental Health:** Co-occurring mental health disorders, such as depression and anxiety, significantly increase the risk of substance use and, consequently, overdose fatalities. The self-medication of these conditions with opioids can lead to addiction and increased overdose risk (Volkow, N.D., et al., 2019).
- **Educational Opportunities:** Lower levels of education are associated with increased risk of substance use disorders and overdose fatalities. Education often affects employment opportunities, income levels, and access to information about the risks of drug use (Lopez, W. D., et al., 2017).
- **Stigma and Discrimination:** Stigma associated with drug use can prevent individuals from seeking help for substance use disorders. Discrimination in healthcare settings can further limit access to effective treatment options (Earnshaw, V., et al., 2019).
- **Criminal Justice Involvement:** Incarceration and criminal justice involvement have been linked to higher risks of opioid overdose upon release. The lack of continuity of care for those with substance use disorders exacerbates the risk (Binswanger, I. A., et al., 2018).

- **Prescription Practices:** Over prescription of opioids and inadequate monitoring of patients have been identified as significant factors contributing to opioid misuse and overdose fatalities (Guy, G. P. Jr., et al., 2017).

6. What are the most effective strategies for preventing opioid overdose fatalities, such as naloxone distribution, safe consumption sites, and medication-assisted treatment?

Prevention Recommendations can be found on page 88, Section 6 of the Opioid Needs Assessment and Statewide Plan. The recommendations on ranked by impact, urgency, and feasibility. The top 3 recommendations most effective strategies are summarized below:

- Establish a "bad batch" communications program to alert communities to prevent mass casualty events.
- Establish a disease investigation model for non-fatal overdoses to identify and mitigate risk.
- Utilize an education and awareness campaign focused on identification of the need for treatment and treatment options, targeted to people using opioids and their families. The campaign should be tailored for different populations in order to promote health equity. Populations targeted should include those without housing.

7. How can we improve access to and utilization of promising and evidence-based harm reduction interventions, particularly among high-risk populations?

One of the DHHS's responsibilities is the development of a Statewide Needs Assessment and a Statewide Plan to identify implementation priorities related to addressing opioid-related harms using a data-driven and evidence-based approach, it's recommended the committee review the document. See page 132 regarding implementing evidence-based practices.

8. How can healthcare systems and community-based organizations better collaborate and coordinate their efforts to address the opioid crisis?

This may be a area to consider MOU's for a more holistic patient care model to include ED induction, crisis care response for opioid poisoning/OD, wrap around services and referrals, etc. Potentially EHR API connections for data sharing and patient care. For example, the creation of the All Payor Claims Database for medical, dental and pharmacy including BH. Continuation of ECHO clinics, Stigma reduction and education for providers. This should also include tribal connections.

9. What recommendations would you like to see in the Regional Opioid Task Force final report made to the Governor's Office and the Director of the Legislative Counsel Bureau?

Recommendations I would like to see in the Regional Opioid Task Force final report can be found in Section 6. Recommendations of the Opioid Needs Assessment and Statewide Plan. These recommendations include data, prevention, treatment, SDOH and Recovery Support recommendations. The DHHS would like to see more of a focus towards youth services, treatment for carceral populations and workforce development.

Mercer

Government Human Services Consulting

Nevada Opioid Needs Assessment and Statewide Plan 2022

State of Nevada Department of Health and Human Services

December 1, 2022

Contents

Section 1

Executive Summary

In 2021, it is estimated that more than 107,000 people died of drug overdose in the United States, marking the highest ever recorded annual number of overdose deaths in the nation.[1] The country's unprecedented overdose crisis, largely driven by opioids, has left no community untouched, including across the State of Nevada (State or Nevada). In response to the alarming rates of opioid misuse, opioid use disorder (OUD), and overdose, Nevada passed Senate Bill (SB) 390 in March 2021, establishing the Fund for a Resilient Nevada (referred to in this document as "the Fund") within the Nevada Department of Health and Human Services (DHHS). This measure was codified at *Nevada Revised Statutes (NRS)* 433.712 through 433.744. One of the DHHS's responsibilities is the development of a Statewide Needs Assessment and a Statewide Plan to identify implementation priorities related to addressing opioid-related harms using a data-driven and evidence-based approach.

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, was contracted by the State to develop the Needs Assessment in partnership with DHHS, the Advisory Committee for a Resilient Nevada (ACRN), and the Attorney General's Office Substance Use Response Working Group (SURG). The Needs Assessment was informed by quantitative and qualitative data, including input from people with lived experience. Between December 2021 and May 2022, Mercer staff collected and analyzed data and information from local and State agencies and organizations, including more than 50 reports provided by DHHS. Mercer staff also conducted stakeholder conversations with key informants and members of ACRN and SURG to gain a more in-depth understanding of the needs across the state.

Data and information were analyzed to better understand the impact of opioid misuse on Nevadans, including:

- The available quantitative and qualitative data related to substance use and rates of OUD, other substance use disorders (SUDs), and co-occurring disorders
- Health equity and the identification of disparities across racial and ethnic populations, geographic regions, and special populations
- The risk factors that contribute to opioid misuse and OUD
- The current state of prevention, treatment, and recovery services for OUD and related issues, such as mental health and other SUDs

Findings from the Needs Assessment demonstrate the impacts the opioid crisis has had on Nevadans, which include 788 overdose deaths occurring in 2020, an increase of 55%

[1] Ahmad, F. B., Cisewski, J. A., Rossen, L. M., & Sutton, P. (2022, June 15). "Provisional drug overdose death counts." National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

compared to 2019. Most overdose deaths involved opioids; however, stimulant use and stimulant-involved overdoses have also increased significantly in recent years. Needs Assessment data show that certain racial and ethnic communities, geographic locations, and other groups have been disproportionately impacted by opioid-related harms. For example, overdose rates among youth have risen 550% between 2019 and 2020, and Hispanic people faced significantly higher increases in overdose death rates compared to other races and ethnicities. Although a large amount of state and local data is available for some populations, trends among certain groups are unknown. For example, little data is available for youth in the juvenile justice system; people experiencing homelessness; and people who identify as lesbian, gay, bisexual, transgender, intersex, queer/questioning, or asexual.

Needs Assessment findings also show that Nevada has built a strong foundation of evidence-based treatment, services, and supports across its current system of care, including prevention, treatment, and recovery supports. However, opportunities for strengthening the current system also exist across all components of care.

Primary, secondary, and tertiary prevention needs that were identified include, but are not limited to:

- School-based prevention programs with measured outcomes that are culturally sensitive
- Prescription drug disposal programs
- Collaborative practice agreements
- Increased adoption of and implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) models in primary care and other community-based settings
- Harm reduction and treatment access trainings for people who use or misuse opioids and/or have experienced a nonfatal overdose
- Programs to decrease stigma among providers and community members
- Increased access to harm reduction services, including syringe services programs
- Community education on the use of naloxone

Treatment needs that were identified include, but are not limited to:

- Increased provider availability for pregnant women with OUD and people with co-occurring SUDs and other conditions
- Increased residential and outpatient medication-assisted treatment programs in rural and frontier areas and justice facilities
- Transportation to treatment and recovery supports
- Increased access to and utilization of opioid treatment programs
- Increased access to office-based treatment for OUD

- Increased access to crisis services

Recovery needs that were identified include, but are not limited to:

- The elimination of prior authorization requirements for peer recovery support services
- Increased access to peer support services for pregnant and postpartum women
- Statewide availability of peer support services throughout the treatment and recovery system

Data gathered through the Needs Assessment were used to identify recommendations that were prioritized based on their impact, urgency, and feasibility, as well as whether they addressed a legislative target area. The Needs Assessment recommendations were categorized based on Johns Hopkins School of Public Health Principles for the Use of Funds from Opioid Litigation[2]:

1. Broaden access to naloxone
2. Increase use of medications to treat OUD
3. Provide treatment and supports during pregnancy and the postpartum period
4. Expand services for neonatal opioid withdrawal syndrome
5. Fund warm handoff programs and recovery services
6. Improve treatment in jails and prisons
7. Enrich prevention strategies
8. Expand harm reduction programs
9. Support data collection and research

Per NRS 433.738 paragraphs (a) through (c), the Statewide Plan recommends funding priorities, which include infrastructure and framework for planning and implementing programs based on broad recommendations resultant from the Needs Assessment. The State will engage stakeholders and other subject matter experts in a more detailed planning process, which will include local subject matter experts to contribute to the planning of activities to fulfill the goals and objectives in the plan. Attention to health equity through Choice Point Thinking and the use of best practices and evidence-based programs are essential to implementing programs that will be effective, sustainable, and equitable for all of Nevada. Appendices to the report provide the required policies and procedures for the distribution of funds as well as requirements for the use of the funds.

[2] Johns Hopkins School of Public Health. *Principles for the Use of Funds from the Opioid Litigation,* 2021. Available at: https://opioidprinciples.jhsph.edu/wp-content/uploads/2021/01/Litigation-Principles.pdf

Mercer worked with the Nevada DHHS, ACRN, SURG, and other stakeholder groups and communities to apply findings from the Needs Assessment to strategically plan how to best apply the Fund for a Resilient Nevada to improve outcomes for all Nevadans.

Section 2
Introduction

From 2011 to 2015, opioid overdoses and prescribing rates were rising across the United States. In 2015, the State of Nevada (State or Nevada) had the second highest prescribing rates of hydrocodone and oxycodone nationally.[3] 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 (DEA) High-Intensity Drug Trafficking Areas (HIDTA) program to determine the critical drug trafficking areas within the state. In 2018, methamphetamines and fentanyl use rates drastically increased; by 2019, Nevada saw opioid overdose deaths with stimulants as a contributing factor drastically increase.

Despite improvement, Nevada ranked twenty-eighth in opioid overdose deaths and twentieth in opioid prescribing in 2019.[4] In 2020, while navigating the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), the United States saw an overall increase by 30% in opioid-related overdose deaths nationwide.[5] Nevada was not spared from the sharp increase. From 2019 to 2020, opioid-related overdose deaths increased by 42% in Nevada. There was also a significant increase in fentanyl-involved overdose deaths by 227%, and opioid-related emergency department (ED) encounters increased by 23%.[6] The percentage of drug-related overdose deaths in people of Hispanic origin increased by 120% from 2019 to 2020, and by 227% for fentanyl-related deaths. No other race/ethnicity categories have shown such a significant increase.[7] Nevada also experienced a sharp rise in polysubstance overdoses and illicit pill consumption. Opioid use within subpopulations in 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 2021, Nevada passed Senate Bill (SB) 390, codified in *Nevada Revised Statutes* (NRS) 433.712 through 433.744, establishing the Fund for a Resilient Nevada within the Nevada Department of Health and Human Services (DHHS).[8] Per NRS 433.736 statewide Needs Assessment must be conducted to establish priorities for the use of the funds described in subsection 1 of NRS 433.732. Such 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. Per NRS 433.736, the Needs Assessment must use qualitative and quantitative data and evidenced-based practices. In addition, NRS 433.726 required the creation of the Advisory Committee for a Resilient Nevada (ACRN) to ensure those with direct knowledge of opioid use disorders (OUDs),

[3] Nevada Overdose to Action and University of Nevada School of Community Health Sciences. *Nevada's Overdose Landscape Presentations*, July 7, 2021.

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

[5] State of 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

[6] Ibid.

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

[8] Senate Bill 390 Overview. (2021). Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Overview

including those with lived experience, were included in the decision-making process. In 2021, Assembly Bill (AB) 374, codified in NRS 458.450 through 458.490, established the Substance Use Response Working Group (SURG) under the Attorney General's Office. All of their duties can be found in NRS 458.480 and includes the study, evaluation and making recommendations regarding substance use prevention, intervention, harm reduction, treatment, recovery and expenditures to address substance use disorders (SUDs)[9] throughout the state.

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, was contracted by the State of Nevada (State) DHHS to objectively review and assess provided documents and materials to assemble a concise Needs Assessment summary with an accompanying presentation for the state's ACRN. The state's Advisory Committee will prioritize recommendations from the Needs Assessment to submit to the DHHS, including feedback from the public and other stakeholder groups.

Following the recommendations from SURG and ACRN, Mercer collaborated with State staff to prioritize funding pursuant to the Statewide Plan to address program areas and target populations focused on the state- level needs identified in the Needs Assessment. This may have involved recommendations on programs to implement or revise new services and other activities to address the identified needs. The Statewide Plan defines the funding priority for the implementation of programs and initiatives. The State will support a high-level budget and evaluate the expected cost of implementing any activities contemplated in developing the Statewide Plan.

[9] Assembly Bill 374. (2021). Available at: https://www.leg.state.nv.us/Session/81st2021/Bills/AB/AB374.pdf

Section 3
Methodology

This document includes both the Nevada Needs Assessment and the Statewide Plan for implementation of mitigation programs and services to address opioid misuse and OUDs in Nevada. Per NRS 433.736, the Needs Assessment uses qualitative and quantitative data and evidence-based practices to determine the gaps and recommendations. The Statewide Plan, per NRS 433.738, establishes policies and procedures for the administration and distribution of money from the Fund; allocates the money in the Fund; and establish requirements governing the use of money allocated from the Fund. The Statewide Plan may allocate money to statewide projects, or grants to regional, county, local and tribal agencies and private-sector organizations whose work relates to opioid use disorder and other substance use disorders. Nevada DHHS is also responsible for ensuring a complete and accurate reporting of the use of all opioid settlement and bankruptcy recoveries for all funded programs.

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

- Quantitative and qualitative data on the use of substances and the rates of an OUD, other SUDs, and co-occurring disorders in Nevada
- Health equity and identification of disparities across racial and ethnic populations, geographic regions, and special populations in Nevada
- The risk factors that contribute to opioid use
- The current state of prevention, treatment, and recovery services for OUDs and related issues such as mental health and other substances

Over 50 reports were provided by DHHS and reviewed by Mercer. A complete list of data sources and resources reviewed can be found in Appendices A and B. Mercer reviewed all reports to pull critical information and data for analysis and synthesis to prepare this report. Mercer presented early concepts and draft outlines of the Needs Assessment to the ACRN and SURG subcommittees for feedback. Mercer also met with various stakeholders to further discuss available reports and data.

Structure of the Report

In accordance with NRS 433.736, the Needs Assessment is evidence-based and uses information from damages reports created by experts as part of the litigation. The Needs Assessment includes a focus on health equity and identifying disparities across all racial and ethnic populations, geographic areas, and special populations. This report identifies health disparities across all racial and ethnic populations, geographic regions, and special populations, where informative data is currently available. With the support of its Office of Minority Health and Equity, Nevada will employ a health equity lens to ensure the

development and implementation of strategies to combat the opioid crisis directly to address the needs of communities disproportionately impacted.

This document is divided into the following sections:

- Section 1: Executive Summary
- Section 2: Introduction
- Section 3: Methodology
- Section 4: Opioid Impact in Nevada
- Section 5: Current System Addressing Opioids in Nevada
- Section 6: Recommendations
- Section 7: Statewide Plan
- Section 8: Next Steps

Sections 3 through 6 comprise the Needs Assessment. Sections 4 and 5 present the opioid impact and currently available systems, as well as the corresponding gaps. The gaps were taken from documents provided by the State. Gaps have been identified through reviews of prior reports and feedback from State staff and the ACRN. Some gaps were implied by data, but absent in the available reports (e.g., there are many prevention efforts in schools, but the use of opioids in adolescents is still relatively high). The gaps identified in sections 4 and 5 informed each recommendation in Section 6. Many of the recommendations were taken from reports submitted by the State. Section 7 provides the Statewide Plan with goals, strategies, objectives, and activities developed from the recommendations and stakeholder feedback that may be funded through the Fund for Resilient Nevada and other funding sources. Section 8 offers details on the next steps for further detailing activities in the Statewide Plan and preliminary allocation proposals.

Scoring Methodology

Mercer used a Likert rating scale to assign a value to the recommendations included in this document. The priority rating reflects Mercer's evaluation of the potential impact of the request, as well as urgency and feasibility. Recommendation topics prioritized in legislation for this needs assessment are identified through a target rating.

Scoring Definitions

The impact, urgency, and feasibility scoring were facilitated by reviewing the factors listed under each area below. The ratings for the elements were averaged within each category to produce a composite rating for each of the impact, urgency, and feasibility categories. They were rated based on whether the recommendation met one of the three legislative priorities: 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 comprising the sum of the impact, urgency, and feasibility ratings with the target rating added to indicate legislative priorities.

Impact

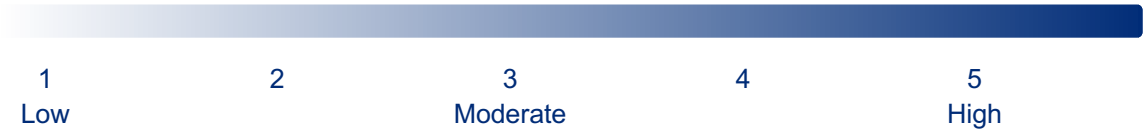
The impact was assigned based on a review of the following factors:

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

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)*



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*

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

High = Recommendation is focused on alleviating disparities/promoting equity

Urgency

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

1. *Availability of alternatives*

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*

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

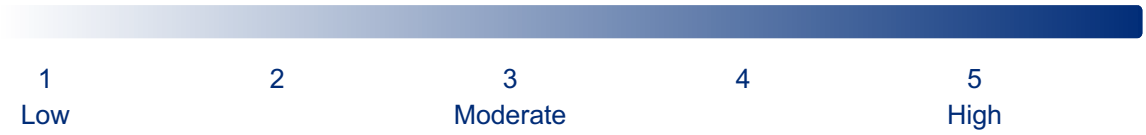
The feasibility was assigned based on:

1. *Current infrastructure*

Low = Infrastructure does not currently exist

High = Existing infrastructure can support recommendation implementation

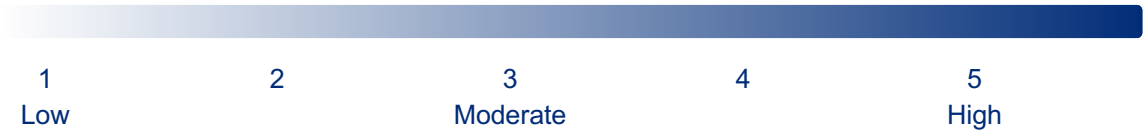
2. *Ease of implementation (effort)*



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

High = Minimal effort required for implementation, easy to implement

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



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

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

Target

Target was assigned based on identification as one of three legislative priorities from NRS 433.736(1)(e), which are consistent with Johns Hopkins Guiding Principles for the use of opioid settlement or bankruptcy recoveries.[10]

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

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

Section 4

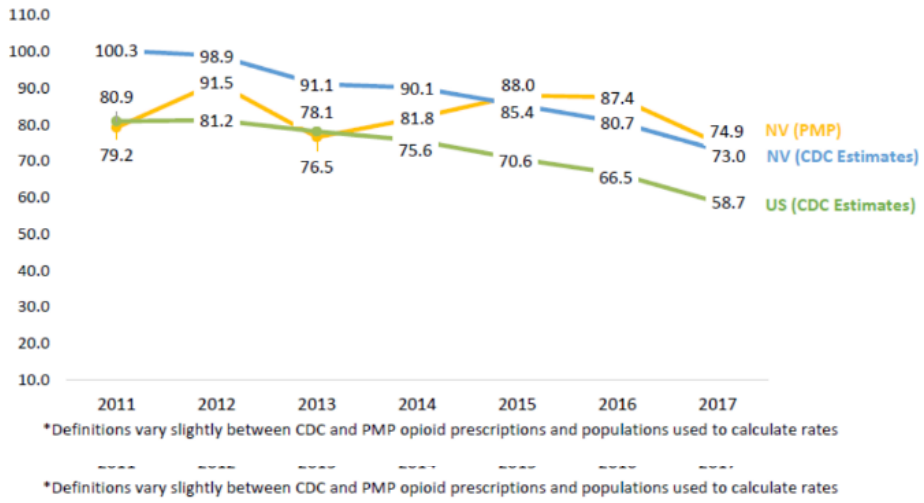
Opioid Impact in Nevada

Nevada has experienced serious impacts from the opioid epidemic over the last 10 years, resulting in high rates of opioid-related overdoses, increased health care utilization, escalating rates of neonatal abstinence syndrome, insufficient access to treatment, and increased family involvement within child welfare. To understand the impact of the opioid epidemic on Nevada, it is important to consider indicators of opioid use, such as prescription monitoring, survey data, criminal justice data, and overdoses, as well as co-occurring behavioral health and comorbid physical health conditions and opioid-related utilization of EDs and hospitals. Focusing on health disparities and the impact on youth within each of these areas further elucidates the impact of opioids.

Opioid Prescribing in Nevada

In 2011, estimates of Nevada's opioid dispensing was 100.3 prescriptions per 100 people, while the US average was 79.2 prescriptions per 100 people. In response to high rates of opioid prescribing, Nevada developed model legislation in 2017 focused on increased utilization of the Prescription Drug Monitoring Program (PDMP), informed decision-making, and best practices for prescribing controlled substances. From January 2017 to May 2022, Nevada has seen a 31% decrease in opioid prescribing in prescriptions per 100 people and a 67% decrease in co-prescribing benzodiazepines and opioids. Opioid prescriptions with a less than 30-day supply and prescriptions with a supply greater than or equal to 90 days both decreased by 54%.

Figure 1. Opioid Painkiller Prescriptions per 100 Population (2011–2017)[11]



*Definitions vary slightly between CDC and PMP opioid prescriptions and populations used to calculate rates

[11] NRS 433.736. "Requirements and procedures for statewide needs assessment." Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec736

Although opioid-related overdoses increased during the PHE, prescribing rates decreased. In 2020, the Centers for Disease Control and Prevention (CDC) reported the national opioid dispensing rate was 43.3 per 100 persons, a decrease from 46.7 per 100 persons in 2019.[12] 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. Three of Nevada's five neighboring states also had opioid dispensing rates higher than the national average in 2020. The State of Idaho, the State of Oregon, and the State of Utah had opioid dispensing rates of 49.9, 45.6, and 48.4 per 100 persons, respectively. The State of Arizona's rate was just under the national rate at 40.5 per 100 persons in 2020, and the State of California's rate was 28.5 per 100 persons, the lowest of the neighboring states.

Specific 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 4.1 below, five of the 17 counties in Nevada had opioid dispensing rates higher than the national average.[13]

Table 4.1. Opioid Dispensing Rate by County in 2020[14,15]

County	Rate per 100 Persons	Difference between County and State Rate*	Difference between County and National Rate*
Carson City	95.9	48.5	52.6
Washoe	53.5	6.1	10.2
Lincoln	48.4	1	5.1
Clark	47.4	0	4.1
Mineral	46.6	−0.8	3.3
Douglas	43.2	−4.2	−0.1
Nye	38.5	−8.9	−4.8
Churchill	38.1	−9.3	−5.2
Storey	29.9	−17.5	−13.4
White Pine	28.6	−18.8	−14.7
Elko	25.2	−22.2	−18.1
Pershing	14.9	−32.5	−28.4
Lyon	10.2	−37.2	−33.1

[12] Centers for Disease Control and Prevention. "Drug Overdose, U.S. State Opioid Dispensing Rates, 2020." Available at: https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html

[13] Ibid.

[14] 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

[15] See Note 12 above.

County	Rate per 100 Persons	Difference between County and State Rate*	Difference between County and National Rate*
Humboldt	9.7	−37.7	−33.6
Lander	1.7	−45.7	−41.6

**Positive numbers indicate that the county rate is higher than state/national rates and negative numbers indicate that the county rate is below the state/national rates.*

Nevada's DHHS Office of Analytics maintains a PDMP dashboard.[16] This dashboard uses data from Nevada's Prescription Drug Monitoring Program (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.

While analytic reports are available for the prescribing rates of opioids and benzodiazepines within Nevada, limited reports are available for other drugs co-prescribed along with opioids, such as gabapentin, which is increasingly associated with overdose deaths nationally.[17] Because many opioid overdoses involve other drugs, such as benzodiazepines, expanding the reports available for drugs tracked by the PDMP would provide better insight into polysubstance use. Reports available through the PDMP are also limited in their description of the characteristics of the individuals receiving prescriptions.

Other Opioid Use Indicators

Survey, arrest, and overdose data are additional means of identifying the prevalence of drugs used without prescriptions. According to the 2019–2020 National Survey on Drug Use and Health (NSDUH), opioid use in Nevada is on the rise, with many substances exceeding US prevalence. The survey estimated the same or higher rates of drug misuse for most drug categories for ages 12 years and up for Nevada, as depicted in Table 4.2 below.[18]

[16] State of 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

[17] Public Library of Science. "Gabapentin may increase risk of fatal opioid overdose." (2017, October 3). Available at: https://medicalxpress.com/news/2017-10-gabapentin-co-use-fatal-opioid-overdose.html#:~:text=Gabapentin%20co-use%20may%20increase%20risk%20of%20fatal%20opioid,1.49%3B%2095%25%20confidence%20interval%201.18%20to%201.88%2C%20p%3C0.001%29.

[18] Substance Abuse and Mental Health Services Administration, *2019–2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia),* 2021. Available at: https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates

Table 4.2. 2019–2020 NSDUH: Model-based Prevalence Estimates[19]

	Estimated percentage			
	Nevada	United States	Nevada	United States
Illicit drug use past month	8.35	7.71	21.16	13.79
Cocaine use past year	0.34	0.36	2.53	2.08
Heroin use past year	—	—	0.39	0.33
Methamphetamine use past year	0.12	0.13	1.41	0.89
Prescription pain reliever misuse past	2.38	1.93	4.02	3.59
Illicit drug use disorder past year	4.39	4.85	8.65	6.82
Prescription pain reliever use disorder past year	0.35	0.32	0.84	0.89

This table presents select estimated percentages of the population based on national survey data. These estimates are presented in the source document with confidence intervals to aid in accurate interpretation. These statistics are estimates based on limited survey data.

Compared to the overall US rates, Nevada is estimated to have slightly higher rates of illicit drug use for adolescents, and much higher rates for those ages 18 years and older. Prescription pain reliever misuse is also estimated to be higher for Nevada than national rates across all age groups.

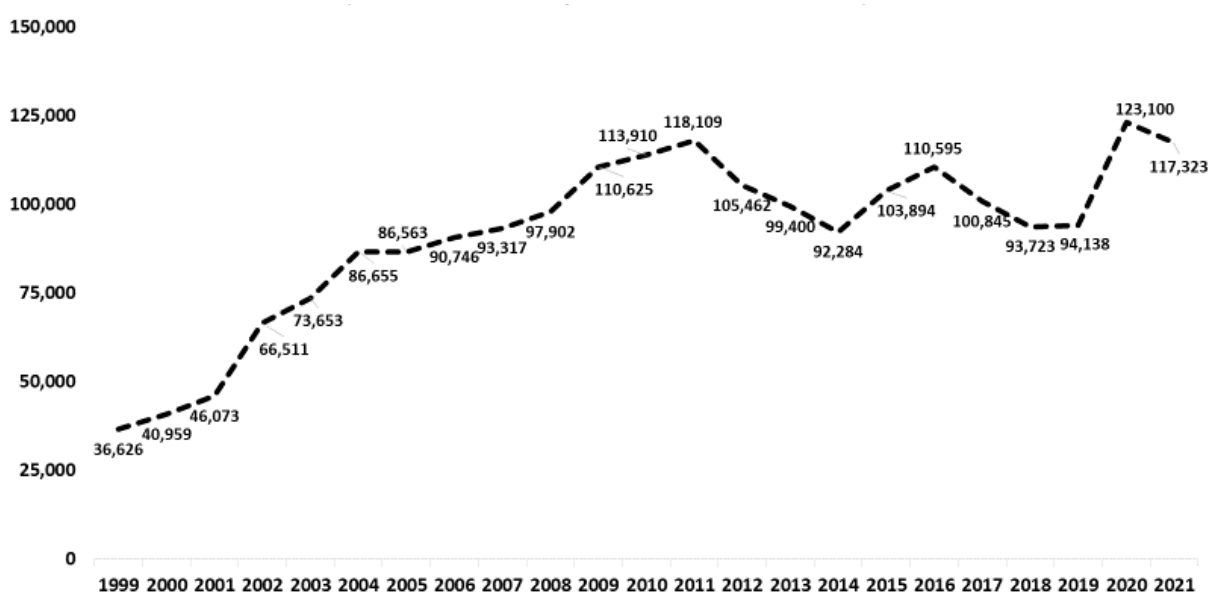
In addition to survey data, opiates, especially illicit fentanyl and heroin, have been identified as high threat substances, in part due to increased availability, seizures, arrests, and overdoses.[20] Fentanyl has increased in risk, with 196% increase in fentanyl overdose deaths between 2019 and 2020. The 2020 Nevada HIDTA report indicates fentanyl has surpassed heroin as Nevada's second biggest threat following methamphetamines.

NSDUH is known to undercount OUDs. To determine more realistic estimates for opioid misuse and OUDs for Nevada, data analyses from other data sources were used for modeling of the prevalence of OUD. Using three different calculations, it is estimated over 117,000 individuals in Nevada met criteria for an OUD in 2021.

[19] Substance Abuse and Mental Health Services Administration, *2019–2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia),* 2021. Available at: https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates

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

Figure 2. OUDs in Nevada, 1999–2021 (2021 based on provisional death count)[21]



Opioid Use in Special Populations

Special populations are defined within NRS 433.722, as veterans; pregnant women; youth; people who identify as lesbian, gay, bisexual, transgender, intersex, queer/questioning, or asexual (LGBTQ+); juvenile justice; and children in the welfare system. Drug-related and opioid-related fatal and nonfatal overdose data are limited for these populations.

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.[22] These characteristics and co-occurring conditions impact individuals on both a systems and individual level, and interventions need to be planned both globally and locally.

Veterans

Nevada's State Unintentional Drug Overdose Report System (SUDORS) data reports the rate of drug-related overdose deaths for military individuals at 6.6% in 2020 (out of 788 total overdose deaths).[23] Despite 6.2% of Nevadans being veterans, there is little additional data on this population and opioids.

[21] NRS 433.736. "Requirements and procedures for statewide needs assessment." Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec736

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

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

Homeless

There is limited data available for individuals experiencing homelessness beyond the 8.9% of drug-related overdoses that were reported in 2020.[24]

Pregnant Women

Based on self-reported data collected by the DHHS' Office of Analytics, an average of 42 babies are 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. The number of substance-exposed infants reported to the Nevada Division of Child and Family Services more than tripled from 2012 to 2020.[25] 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 opioid use.[26] Neonatal abstinence syndrome rates in Nevada were highest in Southern Nevada, with an incidence rate of 8.2 per 1,000 hospital births.[27]

Youth

On the Nevada Youth Behavior Risk Survey in 2019, 8% of high school students reported taking pain medication, such as Adderall®, codeine, OxyContin®, Percocet®, Ritalin®, Vicodin®, or Xanax®, without a prescription or differently than prescribed within the past 30 days.[28] 17% of high school students reported they thought it would be fairly easy to get prescription medication they wanted, while 11.1% thought it would be very easy. 2.2% reported ever injecting drugs.

LGBTQ+

There is evidence that anti-LGBTQ+ discrimination, marginalization, and victimization create elevated levels of stress (often conceptualized as minority stress) that can disrupt an individual's psychological processes, such as the ability to cope adaptively, regulate emotions, and achieve positive interpersonal relationships. External stigma can become internalized, leading to identity concealment, self-hate, feelings of worthlessness, and fear of rejection. To avoid or numb the resulting distress, some people belonging to LGBTQ+ communities may use opioids or other substances.

Certain clinical situations specific to LGBTQ-identified people place them at increased risk of prescription opioid exposure and, therefore, potential misuse. For example, transgender-identified adults with Medicare health coverage were found to have an increased prevalence of chronic pain compared with cisgender (non-transgender) adults.[29]

---

[24] Ibid.

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

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

[27] 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).

[28] Diedrick, M., Lensch, T. Zhang, F., Peek, J., Clements-Nolle, K., Yang, W. *State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. 2019 Nevada High School Youth Risk Behavior Survey (YRBS) Report.*

[29] Girouard, M., Goldhammer, H., Keuroghlian, A. "Understanding and treating opioid use disorders in lesbian, gay, bisexual, transgender, and queer populations," *Substance Abuse*, Volume 40 Issue 3 (2019), pp. 335–339.

LGBTQ-identified people appear to be at elevated risk of opioid use and misuse. According to the 2015 NSDUH, 10.4% of LGB (lesbian, gay, bisexual) adults misused prescription pain medications in the past year, compared with 4.5% of heterosexual adults. LGB adults were also more likely to have a disorder related to pain reliever use compared with heterosexual adults (2.0% vs. 0.7%), and more likely to use heroin in the past year (0.9% vs. 0.3%).[30]

Data from the 2018 NSDUH suggests that substance use patterns reported by sexual minority adults (in this survey, sexual minority adults include individuals who describe themselves as lesbian, gay, or bisexual) are higher compared to those reported by heterosexual adults. Past year opioid use (including misuse of prescription opioids or heroin use) was also higher with 9% of sexual minority adults aged 18 years or older reporting use compared to 3.8% among the overall adult population. Additionally, 9% of sexual minority adults aged 26 years or older reported past year misuse of prescription opioids — an increase from the 6.4% who reported misuse in 2017. However, there was a significant decline in past year prescription opioid misuse among sexual minority adults aged 18 years–25 years, with 8.3% reporting use in 2018.[31]

Juvenile Justice

Data are limited regarding opioid use among those involved with the juvenile justice system in Nevada. National data estimate that 20% of adolescents and young adults in the juvenile justice system are opioid-dependent, with disproportionate rates for people of color.[32]

Children in the Welfare System

In 2020, 1,892 infants were reported to the Nevada Division of Child and Family Services with substance exposure. This number has tripled since 2012.[33] 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. Of those removed, 17.6% were under the age of one year. An additional data analysis estimated that between 2015 and 2019, 9% of child welfare cases and 14% of foster care placements.

Emergency Service Utilization

Poison Control Center Services

Poison control centers provide confidential services to individuals seeking information including the identification of pills, answering questions about drug interactions, appropriate dosing, advising on responses for exposure, and response in the event of overdose. Nevada

[30] Substance Abuse and Mental Health Services Administration. *2019 National Survey on Drug Use and Health: Lesbian, Gay, & Bisexual (LGB) Adults*, 2020. Available at: https://www.samhsa.gov/data/report/2019-nsduh-lesbian-gay-bisexual-lgb-adults

[31] National Institute on Drug Abuse. "Substance Use and SUDs in LGBTQ* Populations." Available at: https://nida.nih.gov/drug-topics/substance-use-suds-in-lgbtq-populations

[32] University of Washington, School of Social Work. "SDRG looks at ways to prevent opioid dependence among incarcerated youth, (2021, May 17). Available at: https://socialwork.uw.edu/news/sdrg-looks-ways-prevent-opioid-dependence-among-incarcerated-youth#:~:text=Nationally%2C%20nearly%2020%25%20of%20adolescents%20and%20young%20adults,which%20is%20a%20strong%20predictor%20of%20subsequent%20re-incarcerations.

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

poison control center data systems indicate that between 2015 and 2019, 30.5% of informational calls and 3.6% of all exposure calls were related to prescription opioids.[34]

Opioid-Related ED and Inpatient Utilization — All Payers

In June 2019, Nevada completed a system-wide assessment using the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Calculating an Adequate System Tool (CAST).[35] The tool results indicate areas of least resources and, therefore, greatest overall risk for substance misuse-related hospitalizations, broken out by county and 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 state's regions are equal to or greater than the national median for substance use-related hospitalization risk.

From 2010 to 2020, opioid-related ED encounters increased by 96%, and inpatient admissions increased by 95%.[36] The rate of ED encounters per 100,000 Nevada residents increased from 109.5 to 184.3, and the rate per 100,000 Nevada residents of inpatient admissions increased from 161.2 to 269.7.

In terms of demographics, in 2021, the rate of opioid-related ED encounters was highest among people of Black, non-Hispanic ethnicity, at 298.4 per 100,000.[37] Inpatient admissions were highest among those reporting white, non-Hispanic ethnicity, at 325.0 per 100,000 Nevada residents. Rates were highest among Nevada residents ages 25 years–34 years (24%). From 2010 to 2020, opioid poisonings in the ED increased by 23%, and inpatient admissions decreased by 25%. The rate per 100,000 Nevada residents in the ED increased from 28.8 to 30.5, and inpatient rates per 100,000 Nevada residents decreased from 22.1 to 14.3.

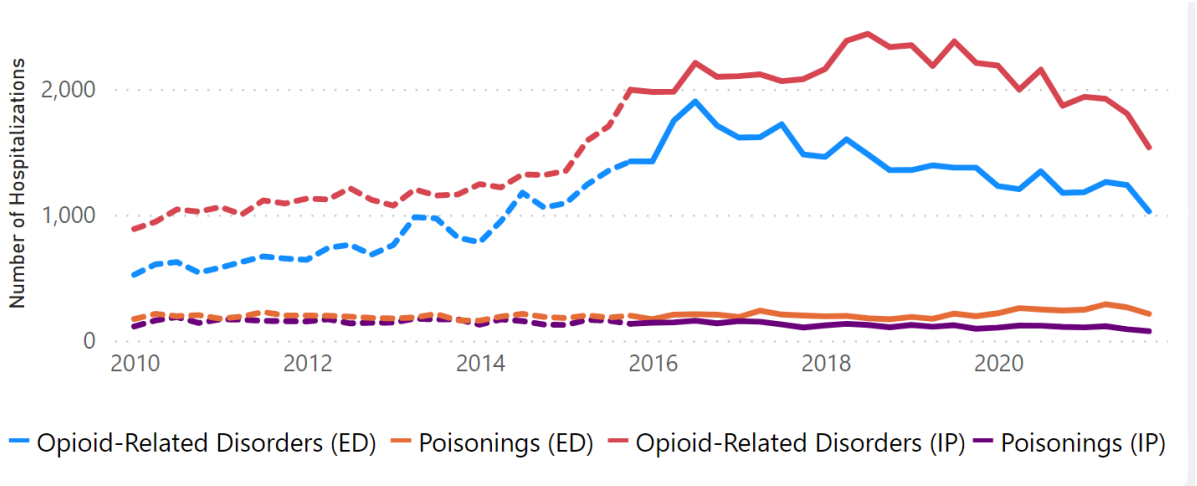
[34] NRS 433.736. "Requirements and procedures for statewide needs assessment." Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec736

[35] State of 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.

[36] State of Nevada Department of Health and Human Services Opioid Dashboard, Available at: https://app.powerbigov.us/view?r=eyJrIjoiODQ2MjJjMjktOWE5NC00MThmLTlkMmEtYzZjMDU0YWU3MmUyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

[37] Ibid.

Figure 3. Opioid-Related Hospitalizations by Quarter, Nevada Residents[38]



Stimulant-Related ED and Inpatient Utilization — All Payers

Nevada has seen sharp increases in methamphetamine and other stimulant use between 2011 and 2020.[39] Methamphetamine-related ED visits increased from 115.7 to 512.7 per 100,000, and inpatient admissions increased from 88.6 to 402.4 per 100,000. Carson City had the highest increases in both ED visits and inpatient utilization related to methamphetamine.

Opioid-Related ED and Inpatient Utilization — Medicaid Payers

From 2010 to 2017, opioid-related ED visits for Nevada Medicaid beneficiaries rose from 400 to 3,463 visits. From 2019 to 2020, opioid-related ED visits increased by 26% (from 2,185 to 2,755 visits), while drug-related ED visits statewide increased by about 3% (from 8,117 visits to 8,352 visits). Table 4.3 depicts the rise in ED visits per 100,000 for December for each month from 2019 to 2021 for opioid and drug-related visits.

In 2018, ED visits and hospitalizations for all opioids except heroin were highest for those aged 15 years–24 years in Humboldt County.[40] In 2021, Medicaid paid 53% of opioid-related ED encounters.[41]

[38] Ibid.

[39] State of Nevada Department of Health and Human Services, Office of Analytics, Methamphetamine and Stimulant Dashboard, data dated November 24, 2011. Available at: https://app.powerbigov.us/view?r=eyJrIjoiY2U2YzNlNmItZDI2OS00YTJlLTk2YmQtNzY1Nzk0MDFkZWMzIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

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

[41] See Note 37 above.

Table 4.3 Medicaid ED Visits per 100,000 Opioids and Other Drugs[42]

	December 2019 Rate per 100,000	December 2020 Rate per 100,000	December 2021 Rate per 100,000
Opioid-related Ed visits	5.8	6.2	7.8
Drug-related ED visits	21.3	20.0	22.1

In 2021, Medicaid paid 44% of the opioid-related inpatient admissions in Nevada.[43] Opioid-related inpatient visits also increased by 97% from 2010–2018, with 317.2 admissions per 100,000 in 2018.[44] Part of this significant increase could be explained by Medicaid expansion in 2014, as the state saw a 25% increase in admissions from 2014 to 2015.

In 2018, 73% of opioid-related ED visits and 73% of opioid-related hospitalizations were among people who are of white, non-Hispanic race/ethnicity.[45] White, non-Hispanic Nevadans aged 25 years–34 years made up the largest percentage of hospitalizations at 28%.

Fatal Opioid Overdoses

Data on opioid overdoses further elucidates the picture of opioid impact in Nevada. This section provides an overview of the magnitude of opioid overdoses in Nevada, while a later section will detail demographic characteristics of those involved in overdoses.

Overdose Data Sources

In 2019, the CDC launched a multi-year 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."[46] 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 NV PDMP. NV-OD2A supports Nevada's SUDORS, National Syndromic Surveillance Program (NSSP), and the NV PDMP.

[42] State of Nevada Department of Health and Human Services, Nevada Overdose to Action, Lawson Institute. *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

[43] State of Nevada Department of Health and Human Services Opioid Dashboard. Available at: https://app.powerbigov.us/view?r=eyJrIjoiODQ2MjJjMjktOWE5NC00MThmLTlkMmEtYzZjMDU0YWU3MmUyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

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

[45] Ibid.

[46] Centers for Disease Control and Prevention. "Drug Overdose, About OD2A." Available at: https://www.cdc.gov/drugoverdose/od2a/about.html

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 and assigned an International Classification of Diseases 10 (ICD-10) code of X40–X44 (unintentional drug poisoning) or Y10–Y14 (drug poisoning of undetermined intent)
- Deaths 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 is limited in that it only includes individuals who can get to an ED.

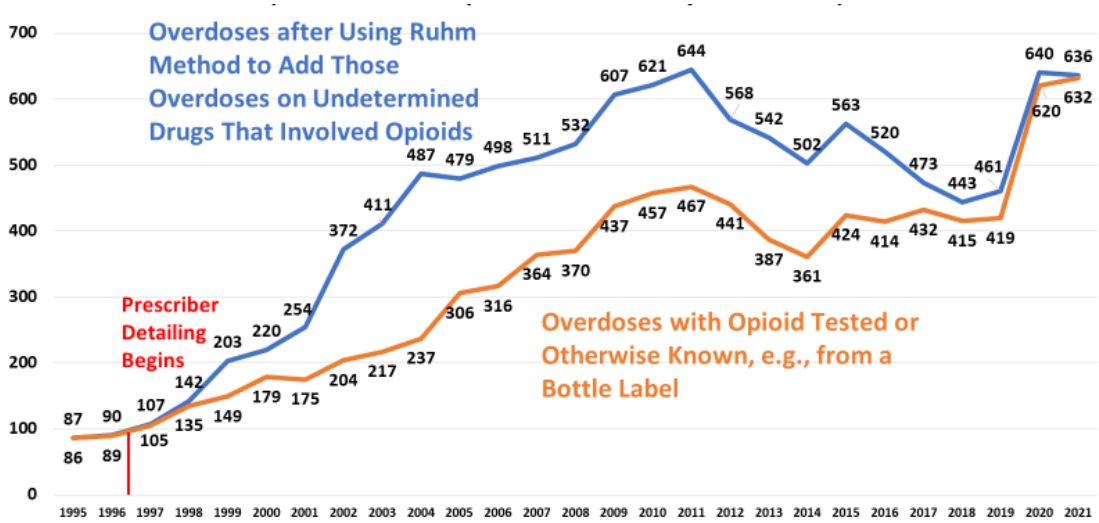
Nevada Overdoses

In 2019, Nevada ranked twenty-eighth in opioid overdose deaths and twentieth in opioid prescribing.[47] In 2020, there were 541 opioid-related overdose deaths among Nevada residents (rate: 17.1 per 100,000). This is a significant increase from 374 in 2019 (rate: 12.0 per 100,000). Preliminary data from 2021 show 269 opioid-related overdose deaths among Nevada residents. Deaths from synthetic opioids (e.g., illicit fentanyl) increased in 2020, from less than 50 in 2010 to nearly 200 in 2020.[48] According to additional data analysis, which includes accounting for overdose deaths from undetermined drugs, it is estimated that previous opioid overdose fatalities have been undercounted.

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

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

Figure 4. Ruhm-Adjusted Opioid Death Counts and the Portion with Drugs Identified by Year, Nevada, 1995–2021[49,50]



First paralleling Keyes et al. (2022), we estimated OUD counts excluding fentanyl from 1999–2021 by dividing Nevada opioid overdose death counts, again excluding fentanyl, by the number of overdose deaths per OUD.[51] Based on a meta-analysis of published ratios, we started with a divisor of 0.0052.[52] The articles underlying this divisor preceded the passage of laws that allowed Emergency Medical Services (EMS) calls for drug overdose without fear of arrest and made the overdose reversal drug naloxone available without a prescription and often without charge. When Nevada adopted those interventions under SB 459 of 2015, it lowered the divisor. We reduced the divisor post-implementation by 26.9% starting in 2016 based on a study that found a Good Samaritan Law reduces the death rate by 15% and a naloxone access law reduces it by 14%.[53] We based a divisor for fentanyl on a study that found fatality risk among people with OUD was 1.62 times higher if the person used fentanyl. 2021 counts are provisional and may underrepresent actual numbers.[54]

Deaths resulting from methamphetamine use increased from 4.4 to 13.7 per 100,000, with the highest prevalence among Black, non-Hispanic males and those between 50 years–59 years old. Stimulant prescriptions increased from 10.1 to 14.7 per 100 residents, with the highest prevalence among females aged 30 years–39 years.[55]

In 2020, opioids contributed to 65.2% of drug-related overdose deaths.[56] Of the opioid-related overdose deaths, 32.4% were due to illicitly manufactured fentanyl (IMF), 28.2% were due to prescription opioids, 15.7% were due to heroin, and approximately 5% were due to methadone. Opioid overdose deaths due to fentanyl increased by 227%

---

[49] NRS 433.736. "Requirements and procedures for statewide needs assessment." Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec736

[50] Ruhm CJ. "Corrected US opioid-involved drug poisoning deaths and mortality rates, 1999–2015," *Addiction*, Volume 113 Issue 7 (2018), pp. 1339–1344. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29430760.

[51] Keyes KM, Rutherford C, Hamilton A, Barocas JA, Gelberg KH, Mueller PP, Feaster DJ, El-Bassel N, Cerdá M. "What is the prevalence of and trend in opioid use disorder in the United States from 2010 to 2019? Using multiplier approaches to estimate prevalence for an unknown population size." *Drug and Alcohol Dependence Reports,* Volume 3, 100052 (2022).

[52] Larney S, Tran LT, Leung J, Santo T Jr, Santomauro D, Hickman M, Peacock A, Stockings E, Degenhardt L. "All-Cause and Cause-Specific Mortality Among People Using Extramedical Opioids: A Systematic Review and Meta-analysis," *JAMA Psychiatry*, Volume 55 Issue 5 (2020), pp. 493–502. Note: Some ratios in the study, but not this one, count extra-medical users of drugs rather than OUDs per overdose death.

[53] McClellan C, Lambdin BH, Ali MM, Mutter R, Davis CS, Wheeler E, Pemberton M, Kral AH. "Opioid-overdose laws association with opioid use and overdose mortality," *Addict Behav*, Volume 86 (2018), pp. 90–95.

[54] Pearce L A, Min J E, Piske M, Zhou H, Homayra F, Slaunwhite A et al. "Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: population based retrospective cohort study," *BMJ*, 2020; 368:m772.

[55] State of Nevada Department of Health and Human Services Opioid Dashboard. Available at: https://app.powerbigov.us/view?r=eyJrIjoiODQ2MjJjMjktOWE5NC00MThmLTlkMmEtYzZjMDU0YWU3MmUyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

[56] State of 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

between 2019 and 2020. Data also identified a 275% increase in amphetamine-related unintentional overdose deaths. Table 4.4 below demonstrates the significant increases contributing to death in opioids, IMF, and amphetamines.[57]

Table 4.4. Top substances contributing to death among unintentional or undetermined overdose related deaths in Nevada, 2019 to 2020

Substance*	2019	2020	Trend*
	N=510	N=788	
Opioids			
Any opioids	292	514	↑ 76.0%
IMF	78	255	↑ 226.9%
Heroin	103	124	↓ 20.4%
Prescription opioids	128	180	
Non-Opioids			
Methamphetamine	264	376	
Benzodiazepines	89	168	
Alcohol	79	97	
Cocaine	52	86	
Diphenhydramine	24	34	
Gabapentin	23	45	
Kratom	16	24	
Amphetamine*	8	30	↑ 275.0%
Polysubstance Abuse			
Opioid + Stimulants	125	210	
Opioid + Benzos	76	149	
Opioid + Alcohol	58	71	

**Only statistically significant differences between 2019 and 2020 rates are included in this table. 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.*

Other Substances Contributing to Overdose Deaths

There has also been an increase in overdose deaths related to multiple substances. According to the CDC, although deaths involving only prescription opioids declined between

[57] Ibid.

2017 (276) and 2018 (235), heroin-involved deaths and those involving synthetic opioids other than methadone (mainly fentanyl and fentanyl analogs) remained stable, with 108 heroin deaths and 85 synthetic opioid deaths in 2018.[58] However, from 2019 to 2020, overdose deaths involving one or more substances increased by 16% (from 263 to 473 overdoses).[59] Overdoses due to stimulants and one or more other substances increased by 17% (147 to 248), with overdose deaths due to opioid and one or more substances increasing by only 4% (228 to 419), controlling for population growth.

There was an increase in overdose deaths involving both an opioid and a stimulant of one person per 100,000 in the Rural Behavioral Health Region and an increase from 0 to 7 people per 100,000 in the Southern Region from 2019–2020.[60] Clark County saw an 80% increase (3.8 to 6.8) while the Washoe Region reported a 21% increase (6.7 to 8.1), with percentages controlling for population growth.[61]

Unintentional overdose deaths involving multiple substances that include fentanyl and benzodiazepines saw a significant increase from 20 deaths in 2019 to 83 deaths in 2020.[62] Clark is the only behavioral health region that reported a similar increase in opioid and benzodiazepine overdose deaths from 2019 (39 deaths) to 2020 (101 deaths). Otherwise, polysubstance overdoses involving benzodiazepines remained relatively stable statewide.

Routes of Drug Administration

The routes of drug administration used by Nevadans who died of an overdose should also be discussed to inform targeted prevention and harm reduction efforts. In 2020, the most common route of administration used in drug-related overdose deaths was ingestion. The percentage of overdose deaths involving ingestion rose from 43.1% in 2019 to 44.4% in 2020.[63,64] The second most common route was smoking, which accounted for 21.0% of deaths in 2020. Snorting/sniffing-related overdose deaths increased by 215.4% between 2019 and 2020 from 26 deaths in 2019 to 82 in 2020.

Population Characteristics of Overdose Cases

Youth

As shown in Table 4.5, overdoses among the under 24-year-old population increased dramatically between 2019 and 2020. Overdose deaths among individuals under the age of 18 years increased from two deaths to 13 deaths (a 550% increase) and from 36 deaths to 93 deaths among those aged 18 years–24 years (a 158% increase).

---

[58] Wilson, N., Mbabazi, K., Puja, S., "Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018," *MMWR Morb Mortal Wkly Rep*, Volume 69 (2020), pp. 290–297. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm

[59] Nevada State Opioid Response. *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

[60] Ibid.

[61] Ibid.

[62] Ibid.

[63] Note that the total number of overdoses in 2019 was 510 and in 2020 it was 788, therefore comparisons of the significance of the percent of increase should be interpreted with caution.

[64] State of Nevada 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

Racial/Ethnic Disparities

Evidence clearly shows that Black, Indigenous, and other people of color who use drugs or have SUDs experience disproportionately negative outcomes due to discriminatory systemic policies and practices. For example, people of color have less access to evidence-based treatment, receive lower quality of care, and are more likely to be punished for their substance use, compared to white people. In 2020, Nevada's diverse population included people who are Hispanic and Latino (28.7%), Black and African American (12.1%), Asian (11.4%), American Indian and Alaska Native (3.4%), and Native Hawaiian and Other Pacific Islander (1.7%), among others.[65] Nevada is also home to many immigrants. In 2018, immigrants comprised nearly 20% of Nevada's population, half of whom were naturalized US citizens. Approximately 210,000 people in Nevada lacked a legal immigration status in 2016. 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, all of which are characteristics that also make the experience of health disparities more likely.

Nevada has 27 federally recognized tribes, each with separate reservations or colonies, and 97% of which are rural.[66] American Indian/Alaskan Native (AI/AN) make up 1.2% of Nevada's population and experience a variety of risk factors for disparities in SUDs and treatment, 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.

The overdose death rates for AI/AN people in Nevada (14.0 per 100,000) were higher than that of Hispanic (6.3 per 100,000) or Asian/Pacific Islander (3.2 per 100,000) Nevadans. From 2015–2020 negative health consequences and substance use rates among AI/AN people in Nevada were consistently high.[67]

As shown in Table 4.5, from 2019–2020, the statewide percentage of drug-related fatal overdoses increased by 119.7% for Hispanic populations and 43.7% for white populations.[68] The majority of unintentional drug-related overdoses in Nevada in 2019 and 2020 occurred in white men, 25 years–64 years of age, with a high school diploma.

It is also important to note that while the rate of growth of the Hispanic population is projected to be 21% from 2021 to 2031 (more than twice that of the overall population [9.3%]),[69] 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, and by 227% for fentanyl-related deaths. No other race/ethnicity categories have shown such a significant increase.[70]

---

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

[66] Ibid.

[67] 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.

[68] State of 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

[69] Griswold, T., Packham, J., Warner, J., & Etchegoyhen, L. *Nevada rural and frontier health data book – tenth edition.* University of Nevada, Reno, 2021.

[70] Larson Institute/Nevada Overdose to Action. *2020 Hispanic/Latinx Overdose*, 2021.

Table 4.5. Statewide Drug-Related Overdose Death Demographics[71]

Demographics			
Sex			
Male	326	538	
Female	184	250	
Race/Ethnicity			
Asian/Pacific Islander	18	19	
Black (non-Hispanic)	72	107	
Hispanic	66	145	↑ 119.7%
White	343	493	↑ 43.7%
Other	5	9	
Age			
<18 years	2	13	↑ 550.0%
18 years–24 years	36	93	↑ 158.3%
25 years–34 years	83	149	
35 years–44 years	99	144	
45 years–54 years	120	158	
55 years–64 years	126	162	
65+ years	44	69	
Education			
Less than high school	66	118	
High school/GED	271	391	
Some college	56	101	
Associates	31	62	
Bachelors	32	47	

**Only statistically significant differences between 2019 and 2020 rates are included in this table. 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.*

[71] See Note 67 above.

Geography of Overdose Fatalities

Statewide and Regional Overdose Fatalities

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, as shown in Table 4.6. Of those deaths, 65.2% were attributable to opioids.[72]

In the Northern Behavioral Health Region[73] of the state, opioids were listed as the cause of death for 61% of overdose deaths and 67% of overdose deaths in the Southern Behavioral Health Region.[74]

Table 4.6. State and Regional-Level Drug-Related Overdose Death Rates

	2019	2020	Percentage 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.*

County-Level Overdose Fatalities

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.[75]

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 County, Lyon County, and Storey County); and the other 11 counties are classified as frontier. This means over half of the counties (64.7%) within Nevada are considered frontier. While 90.9% of Nevada's population resides in urban areas, 13.1% of the state's land, the remaining 9.1%

[72] State of 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

[73] Includes the following counties: Washoe, Carson City, Storey, Douglas, Lyon, Churchill, Mineral, Esmeralda, Lincoln, Humboldt, Pershing, Lander, Eureka, Elko

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

[75] University of Nevada, Reno School of Medicine, *Nevada Rural and Frontier Health Data Book,* 2021.

of the population lives in rural or frontier counties, which spans 86.9% of the state's land, approximately 95,431 square miles.

With almost 9.1% of the population in rural or 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 Nevada-born residents, at approximately 27.7% compared to 26.3% in urban counties.

While 75.5% of the population in rural and frontier counties is white, 17.3% of the population in these counties is Hispanic. Approximately 13.8% of the Nevada veteran population live in rural and frontier counties. 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. 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).

The frontier counties of Mineral, Lincoln, Eureka, and Esmeralda, and the rural county of Storey, have the smallest populations (less than 5,000 persons) in Nevada. Lincoln County's opioid-related overdose death rate was 19.3 per 100,000 in 2020, one of the highest rates in Nevada. Due to low populations, the rate of opioid-related overdose death rates could not be reported for Storey, Eureka, and Esmeralda Counties (see Table 4.7).[76] Of the remaining frontier counties, Douglas, Humboldt, Pershing, and Lander Counties all reported increases in the rate of opioid-related drug overdoses in 2020.

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. Although Carson City experienced a decrease in the rate of opioid-related overdose deaths, Clark and Washoe Counties experienced increases.

Rates of drug-related and opioid-related overdoses increased in nine of the 12 counties with reportable rates from 2019 to 2020, as seen in Table 4.7 below. Douglas, Elko, and Nye Counties experienced increases by at least 10 deaths per 100,000 in 2020. While the change in rate from 2019 to 2020 cannot be calculated for Lander, Lincoln, and Pershing Counties, due to the 2019 rate of zero or too low to report, it can be inferred that the rates have significantly increased because 2020 data are above zero and reportable.

Table 4.7. Drug-Related and Opioid-Related Overdose Death Rates[77]

County	Drug-Related Overdose Death Rates			Opioid-Related Overdose Death Rates		
	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

[76] State of Nevada Department of Health and Human Services. *Suspected Nevada Drug Overdose Surveillance Monthly Report, January 2022: Statewide Report.*

[77] State of 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

County	Drug-Related Overdose Death Rates			Opioid-Related Overdose Death Rates		
	2019	2020	Change	2019	2020	Change
	19.2	24.5	↑ 5.3	11.0	16.6	↑ 5.6
Elko	5.5	12.7	↑ 7.2	1.8	12.7	↑ 10.9
Eureka	—	—	—	—	—	—
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 rate may be 0 or was suppressed due to low counts. "" indicates a change in the rate could not be calculated*

Availability of Opioids and Other Drugs

Polysubstance use in Nevada has been on the rise from 2019 to 2020.[78] The Nevada HIDTA found several polysubstance issues when reviewing both drug trafficking and use in the state.[79] 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, and in April of 2022, the DEA released a letter warning states of mass overdose events caused by fentanyl-laced drugs which the victims did not know contained fentanyl.

Stimulants

Methamphetamine is in abundant supply due to the low cost of making the drug. Although the overall rate of methamphetamine arrests accounted for 61% of all drug-related arrests in

[78] Nevada State Opioid Response. *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

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

Las Vegas, these arrests declined by 11% from 2019 to 2020.[80] As evident in Table 4.2, methamphetamine use in Nevada is estimated to be higher than national estimates.

The age range accounting for most of the methamphetamine-related arrests were adults aged 25 years–34 years, followed closely by adults aged 35 years–44 years. Data received from both the Clark County Office of the Coroner/Medical Examiner and the Washoe County Regional Medical Examiner's Office indicate that methamphetamine is still the most prevalent illicit drug encountered in overdose deaths, followed by fentanyl in 2020. They also indicate that heroin, cocaine, and methylenedioxy-methamphetamine were attributed to increases in overdose deaths.

Geography Contributing to Availability

The geography of Nevada and the surrounding areas contribute to the availability and distribution of opioids. Nevada has primarily desert landscape with many mountain ranges. The large expanse of the interstate highway through frontier and rural areas provides a direct route for drug traffickers to move and sell drugs. Highways have minimal traffic which allow for transportation of narcotics on interstates that connect to California, Utah, Arizona, and other areas on less traveled transportation routes.

In addition, Las Vegas presents a unique challenge with its high occurrence of gaming, money laundering, and drug trafficking. Initially, the PHE 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 as 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.

Many of the substances coming into the state originate in Mexico and are brought across the border with personal and commercial vehicles. Mexican drug trafficking organizations continue to be the predominant source of supply for the primary substance 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.

[80] Ibid.

Technology Contributing to Availability

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, particularly for fentanyl-laced pills.

Gaps in Opioid Data

- Reports indicating duplication of individuals and appropriateness of prescribing in the PDMP
- PDMP reporting for other drugs that are being co-prescribed along with opioids, such as gabapentin
- Single-point of information-gathering for comprehensive aspects of Nevada-based opioid data, including other commonly co-occurring substances
- Demographic-based reports indicating characteristics of people more likely to receive aberrant prescriptions for opioids
- Race/ethnicity data and indicators of membership in special populations in all opioid-related data (special populations include veterans, homeless population, pregnant women, youth, LGBTQ+, juvenile justice, and children in the child welfare system)

SUD and Co-Occurring Behavioral Health and Comorbid Physical Health Conditions

Co-Occurring Behavioral Health Disorders

Co-occurring mental illness and OUDs are common in both adults and children.[81] 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.[82]

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

[81] National Institute on Drug Abuse. *Part 1: The Connection Between Substance Use Disorders and Mental Illness*, 2021. Retrieved from https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness

[82] Ibid.

across the country are given to individuals with depression or anxiety. Additionally, people 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.

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.[83] 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 symptoms than do people without a comorbid mental health diagnosis.[84] 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.

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 US in 2017.[85]

In 2020, approximately 34.5% of individuals who died due to a drug-related overdose in Nevada had a co-occurring mental health problem.[86] Of the drug-related overdose deaths of people of Hispanic origin, 25% reported a prior mental health problem while 7% reported a non-alcohol-related substance use issue.[87]

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.[88] While data are available indicating whether a co-occurring mental health condition was present, information is limited on the types of behavioral health conditions, and the demographics of those individuals are not available. This is primarily due to how overdose deaths are reported.

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.[89] Over 600 people die by suicide each year in Nevada, with approximately 12% occurring in youth.

---

[83] Goldner EM, Lusted A, Roerecke M, Rehm J, & Fischer B. "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*, Volume 39 Issue 3 (2014), pp. 520–531.

[84] Zhu, Y., Mooney, L.J., Yoo, C., Evans, E.A., Kelleghan, A., Saxon, A.J., Curtis, M.E., & Hser, Y. "Psychiatric comorbidity and treatment outcomes in patients with opioid use disorder: Results from a multisite trial of buprenorphine-naloxone and methadone," *Drug Alcohol Dependence*, Volume 228 (2021).

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

[86] Nevada State Opioid Response, *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

[87] Larson Institute/Nevada Overdose to Action. *2020 Hispanic/Latinx Overdose*, 2021.

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

[89] State of Nevada Department of Health and Human Services: Office of Analytics, *Youth Suicide: Behaviors and Circumstances, Nevada 2020*, February 2022. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Youth%20Suicide%20Behaviors%20and%20Circumstances%20Nevada%202020.pdf

There is limited data available for suicides that involve drugs, particularly opioid overdoses. Information about death from suicide can often be challenging due to the variation in methods hospitals use for medical record documentation.

SUDORS data demonstrates 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.[90] In 2019, suicide was the leading cause of death for those ages 10 years–17 years, and the second leading cause of death for those ages 18 years–24 years.[91] From 2017 to 2020, youth suicide rates were highest in males (75.3%), occurring mostly in white and Hispanic populations (46.8% and 28.6%, respectively).

Suicide 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.[92] From 2016 to 2020, about 88% of veterans who died by suicide were white, 5% were Black, and 3% were Hispanic. Veteran suicides are occurring at the highest rate among individuals 20 years–34 years of age. SUDORS data indicated that 6.6% of drug-related overdose deaths occurred in active-duty military members or veterans, although the delineation between active and veteran cannot be delineated due to the method of data capture.

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 and called 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.

Co-Occurring SUDs

As noted previously, polysubstance use in Nevada has been on the rise from 2019 to 2020. Overdose deaths involving one or more substances increased by 16%, with substances including opioid and one or more substances having increased by 4%, and stimulants and one or more other substances having increased by 17%.[93]

Nevada recognized the need to address polysubstance use as part of its response to the opioid crisis. The Las Vegas-based Eighth Judicial Medication-Assisted Treatment (MAT) Re-entry Court has expanded the population they can serve with State Opioid Response (SOR) II funds, allowing them to enroll individuals with a stimulant use disorder into the program. The first client was admitted into this program in March 2021.[94]

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

---

[90] State of 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

[91] See Note 88 above.

[92] State of Nevada 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

[93] Nevada State Opioid Response. *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

[94] 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.

needs of individuals with methamphetamine or other addictions, which will need to be addressed simultaneously during treatment.

Physical Health Comorbidities

SUD is often accompanied by physical health conditions. The National Institute of Drug Abuse found that chronic pain conditions, cancer, and heart disease are common physical health disorders in those with SUDs.[95] Chronic pain conditions, tobacco use, and infectious disease are strong contributors to SUDs, especially OUD.

Chronic Conditions

The CDC 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.[96] In fact, patients with two or more chronic conditions accounted for over 90% of opioid-related hospitalizations from 2011 to 2015.[97]

More than 30% of individuals in the US have some form of an acute or chronic pain disorder.[98] Approximately 10% of people with chronic pain disorders misuse prescription opioids.[99] The Nevada DHHS Office of Analytics PDMP 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 days–90 days. As depicted in the PDMP Dashboard (Table 4.8 below), chronic pain disorders (e.g., dorsalgia, nerve pain, joint/muscle pain) are the top diagnoses for opioid prescriptions.[100] Chronic pain conditions can also be exacerbated by behavioral health conditions, such as depression and anxiety,[101] which increases a person's risk for developing SUD.

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

[96] 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*, Volume 16 (2019).

[97] US Department of Labor, "Risk Factors for Opioid Misuse, Addiction, and Overdose." Available at: https://www.dol.gov/agencies/owcp/opioids/riskfactors

[98] Longo, D. "Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies," *New England Journal of Medicine*, Issue 374 (2016), pp. 1253–1263. Available at: https://www.nejm.org/doi/pdf/10.1056/NEJMra1507771?articleTools=true

[99] 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

[100] State of 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

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

Table 4.8 Top 10 Diagnoses for Opioid Prescriptions with Supplies less than 30 Days, Greater than 90 Days, and 30 Days–90 Days[102]

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

Viral Infections

Individuals suffering from OUD who inject or administer drugs intravenously have 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.[103] A recent Nevada report on HIV indicated that, in 2020, there were 15 new cases of HIV through injection drug use and 14 new cases through injection drug use combined with male-to-male sexual contact (MSM), most of which occurred in Clark County.[104] Additionally, 754 Nevadans are known to be living with HIV transmitted through injection drug use, and 755 through MSM and injection drug use.

Hepatitis is a viral inflammatory disorder that often involves pain. Individuals with untreated hepatitis C may experience joint pain, and those with hepatitis B may experience joint and

[102] State of Nevada Department of Health and Human Services Prescription Drug Monitoring Program Dashboard, data for 2021. Available at: https://modi-dark.talusanalytics.com/resource/nevada-prescription-drug-monitoring-dashboard/

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

[104] State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health, Office of HIV and Office of Analytics, *Nevada 2020 HIV Fast Facts, 2020*

abdominal pain. Individuals who contract HIV may also experience joint and muscle pain due to inflammation. Therefore, not only are people who use opioids through injection or intravenously at risk for contracting these diseases, but chronic pain associated with the diseases increases the likelihood of opioid misuse.

Bacterial Infections

In the July 2017 edition of the CDC's Morbidity and Mortality Weekly Report, the CDC studied the bacterial and fungal infections of persons who inject or use drugs intravenously in Western New York, an area with a high rate of opioid overdoses.[105] Bacterial and fungal infections, such as infective endocarditis, osteomyelitis, pneumonia, empyema, septic arthritis infections, central nervous system abscesses, and skin and soft tissue infections are associated with SUDs.[106] Approximately 74% of the opioid users included in the study had infections in the skin and soft tissue. Approximately 24% of the people who use opioids with these types of infections were hospitalized for at least 30 days.[107] Data limitations of the study include an underestimate of bacterial and fungal infections because some individuals do not seek care; therefore, there is a lack of outpatient visit information. For those who do seek care, medical records do not always specify the route of drug administration.

While not specific to Nevada, the study provides insight into the type of infections that could develop, interventions that could help to avoid these types of infections, and the cost of care that is associated with these infections. The CDC notes that although the study is limited to a small population, that does not lessen the point that these skin and tissue infections could be prevented by using proper hand hygiene and cleaning the site prior to injection. Education regarding hygiene and safe equipment could have a positive impact on these rates.

Also in Nevada, the number of annual cases of congenital syphilis, another bacterial infection commonly associated with injection drug use, has risen by 12%[108] between 2019[109] (114.7 per 100,000 live births) and 2020[110] (131.2 per 100,000 live births). Nevada has consistently ranked fourth in the nation for rates of reported congenital syphilis in 2019 and 2020.

[105] Hartnett, K., Jackson, K., et al., "Bacterial and Fungal Infections in Persons Who Inject Drugs – Western New York, 2017" *MMWR Morb Mortal Wkly Rep,* Volume 68 Issue 26 (2019), pp. 583–586. Available at: https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6826a2-H.pdf

[106] McCarthy, N., Baggs, J., See, I., Reddy, S.C., Jernigan, J.A., Gokhale, R.H. & Fiore, A.A. "Bacterial Infections Associated with Substance Use Disorders, Large Cohort of United States Hospitals, 2012–2017." *Clinical Infectious Diseases*, Volume 71 Issue 7 (2020), pp. e37–e44. Available at: https://academic.oup.com/cid/article/71/7/e37/5697426

[107] Ibid.

[108] Casado, F. "Cases of babies born with syphilis rise in Nevada in 2020." Kolo TV, April 19, 2022, accessed May 2, 2022. Available at: https://www.kolotv.com/2022/04/19/cases-babies-born-with-syphilis-rise-nevada/

[109] Centers for Disease Control and Prevention, "Sexually Transmitted Disease Surveillance 2019, Table 40. Congenital Syphilis — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2019." Available at: https://www.cdc.gov/std/statistics/2019/tables/40.htm

[110] Centers for Disease Control and Prevention, "Sexually Transmitted Disease Surveillance 2020, Table 20. Congenital Syphilis — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2020." Available at: https://www.cdc.gov/std/statistics/2020/tables/20.htm

Gaps Related to SUD and Co-Occurring Behavioral and Physical Health Conditions

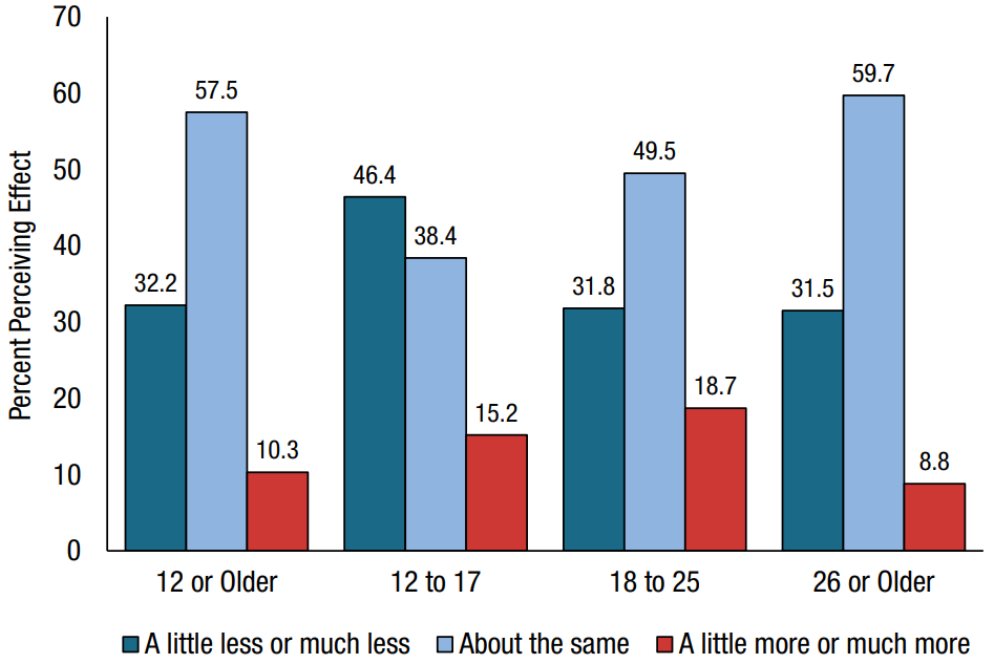
- Data that accurately capture co-occurring behavioral health and physical health conditions within Nevada's OUD population
- Zero Suicide Initiative is progressing, but still lacking in sufficient training on suicide signs, risk factors, and evidence-based interventions applicable to suicide and substance use. Efforts are needed in the school system, for parents, for law enforcement, and for other community partners
- Data on health outcomes, especially longitudinal data stratified according to population characteristics
- Data on co-occurring substance use and treatment access for individuals using multiple substances
- Capacity for crisis intervention in the community rather than in EDs and inpatient

COVID-19 PHE Impact

The data presented in this report are as current as available and, therefore, include data collected during the COVID-19 PHE. The impact of COVID-19 on the opioid epidemic is mixed, with significant increases in overdoses and overdose deaths across the country, and yet reports of less substance use during the PHE per the 2020 NSDUH.[111] The NSDUH demonstrates that rising numbers during the PHE are not necessarily due to increasing use among those already using opioids. Figure 5 shows that most respondents reported using drugs other than alcohol about the same or less than they had prior to COVID-19.

[111] Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, 2021.

Figure 5. Perceived COVID-19 PHE Effect on Drug Use: Among Past Year Users of Drugs Other than Alcohol Aged 12 Years or Older; Quarter 4, 2020.[112]



Note: Use of drugs other than alcohol included the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year. Drugs other than alcohol did not include tobacco products or nicotine vaping.

Note: The percentages do not add to 100 percent due to rounding.

As shown in Figure 5, the Survey reported that in Quarter 4 of 2020:

- Among people aged 12 years or older who used drugs other than alcohol in the past year, about one in three perceived that they used these drugs "a little less or much less" than they did before the COVID-19 PHE began, and more than half (57.5% or 60.6 million people) perceived that they used these drugs "about the same" as they did before the COVID-19 PHE began. An estimated 10.3% of past year users of drugs other than alcohol (or 10.9 million people) perceived that they used these drugs "a little more or much more" during the COVID-19 PHE than they did before. It is not known, however, whether people who reduced or increased their use of these drugs will return to their earlier levels of use over time.
- Nearly half of adolescents aged 12 years to 17 years who used drugs other than alcohol in the past year (46.4% or 2.0 million people) perceived that they used these drugs "a little less or much less" than they did before the COVID-19 PHE began. This percentage among adolescents was higher than the corresponding percentages among young adults

[112] Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, 2021. (page 50). Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

aged 18 years to 25 years (31.8% or 4.2 million people) and those aged 26 years or older (31.5% or 27.7 million people) who used these drugs. In relation to perceived reductions in alcohol use, these adolescents could increase their use of other drugs, as they have more opportunities to engage in social activities with peers.

- Adolescents and young adults who used drugs other than alcohol in the past year were more likely than their counterparts aged 26 years or older to perceive that they used these drugs "a little more or much more" than they did before the COVID-19 PHE. Specifically, 15.2% of adolescents (or 665,000 people) and 18.7% of young adults (or 2.5 million people) perceived that they used these drugs "a little more or much more" than they did before the COVID-19 PHE began. In comparison, 8.8% of adults aged 26 years or older who used drugs other than alcohol in the past year (or 7.7 million people) perceived that they used these drugs "a little more or much more" than they did before the COVID-19 PHE.

In 2020, health service utilization for conditions other than those related to COVID-19 decreased, particularly during the first months of the PHE and into 2021.[113] It is significant that opioid-related ED visits increased during this period when individuals were, for the most part, not accessing services. It suggests that the decreased utilization of outpatient services and/or the effects of the PHE could have driven some of the ED utilization presented later in the report. The survey above suggests that these may be among a mix of people who are new to opioid use and those who have continued use from before the PHE.

Finally, felony admissions for drug possession dropped nearly 17% during the PHE, while the justice system saw a 20% increase in admissions among people with behavioral health treatment needs.[114]

In Summary: Opioid Impact in Nevada

The impact of the opioid epidemic in Nevada, from opioid and polysubstance use, to co-occurring behavioral health and physical condition comorbidity, overdose, and ED and hospital utilization, is just beginning to be fully understood with the data and analyses that are available. The impact of the COVID-19 PHE on the opioid epidemic made trends more difficult to identify. Although the data is somewhat limited, it is feasible to identify recommendations based on gaps identified in this section.

Findings and Gaps Summary

- Nevada 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. Opioid and polysubstance use is increasing rapidly, with alarming increases in subsequent deaths from suicide and overdose. The National Drug Helpline placed Nevada on "red alert" status for increased risk of death from overdose.
- Health disparities are not fully understood and require high-priority attention. Capturing race/ethnicity, as well as population data, would provide insights into health equity. These

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

[114] Crime and Justice Institute, Nevada Sentencing Commission Presentation: "Impact of COVID 19 on Nevada's Prison Population: Project Update," September 2021.

insights would support prioritizing populations and developing interventions that are designed for and meet specific needs of these populations.

- There are several contributors to the availability and distribution of substances: Nevada's location and geography, the increasing use of technology and digital means, and provider prescribing patterns. While opioid prescribing rates are declining, Nevada maintained a higher dispensing rate than the national average. It will be important for Nevada to capture diagnoses and other drugs co-prescribed with opioids. This insight would assist in a better understanding of the extent of appropriate and inappropriate provider prescribing patterns. The State could then collaborate with managed care organizations (MCOs) to develop and implement outcome-based programs to support appropriate provider prescribing and curb member behaviors that contribute to seeking multiple prescribers.
- Those with co-occurring behavioral health disorders and/or physical health comorbidities have a greater likelihood of receiving one or more opioid prescriptions and, subsequently, are at greater risk of developing OUD. Access to behavioral and physical health services in the state could be further assessed to ensure these services are available to those who need them in the way that they need to access them to proactively manage these types of conditions.

Section 5

Current System Addressing Opioids in Nevada

Nevada's multiple agencies and stakeholder groups are responsible for reducing harms related to opioid misuse, opioid overdose, and OUD through prevention, treatment, harm reduction, and recovery supports. The following section reviews the current system and identifies gaps in access and availability of programs and services that are likely contributing to vulnerabilities leading to adverse impacts of opioid misuse, opioid overdose, and OUD on the residents of Nevada.

Prevention

The SAMHSA recommends five steps and two guiding principles within its Strategic Prevention Framework ("Framework") that should be applied when planning prevention interventions and programs to decrease substance use-related risks and harm. The Framework's five steps include assessment, capacity, planning, implementation, and evaluation. Cultural competence and sustainability should be considered key principles in the five steps. The Framework offers jurisdictions a systematic approach to identifying and prioritizing specific problems, affected populations, protective factors, and resources; building community awareness, engagement, and capacity; selecting appropriate interventions and developing comprehensive project plans; implementing programs with fidelity and appropriate adaptations; and evaluating prevention programs.[115]

A range of evidence-based prevention strategies can be applied to reduce risks across a continuum of substance use, including preventing opioid misuse and OUD. Additionally, prevention efforts may be designed to offer universal, selective, or individualized interventions. For purposes of this report, three categories of prevention efforts are discussed: primary, secondary, and tertiary. Tertiary prevention efforts are primarily addressed in the context of harm reduction. The 2019 assessment of the overall Nevada behavioral health care system identified that prevention is at 84% unmet need/insufficient capacity statewide.[116]

Primary Prevention: Preventing Misuse and New Cases of OUD

Primary prevention aims to prevent disease or injury by avoiding exposure to the hazards that cause the disease or damage, altering behaviors that increase risks, and increasing

[115] Substance Abuse and Mental Health Services Administration. *A Guide to SAMHSA's Strategic Prevention Framework*, 2019. Available at: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

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

resistance to disease or injury if exposure does occur.[117] In the context of OUD, primary prevention includes efforts to prevent opioid misuse and reduce risk of OUD if misuse does occur. Examples of primary prevention efforts include identifying and addressing adverse childhood experiences (ACEs), offering school-based prevention education, educating providers on safe prescribing practices, and implementing public education campaigns to increase awareness of ways to prevent opioid misuse and OUD. Nevada is implementing several evidence-based primary prevention efforts to prevent opioid misuse, opioid overdose, and OUD, which are discussed below; however, opportunities to expand prevention efforts in the state also exist. The 2019 system-wide assessment using SAMHSA's CAST identified prevention services as the second highest collective need for Nevada, based on a comparison of regional priorities.[118]

Identifying and Addressing ACEs

A large body of evidence clearly shows that ACEs, such as physical and emotional abuse, neglect, or household dysfunction, are strongly correlated to a higher risk of substance misuse, SUDs, and other substance use-related harms.[119,120,121,122] Among people with OUD, ACEs are positively correlated with overdose, injection drug use, and earlier age of opioid initiation.[123] ACEs impact people across the lifespan and can lead to an earlier death.[124] Prevention and early identification of ACEs and interventions to address childhood trauma are recommended to prevent substance use and other health-related risks among youth and adults across the lifespan.[125]

Impact of ACEs on Youth in Nevada[126]

The Youth Risk Behavior Survey (YRBS) is a national surveillance system established in 1991 by the CDC to monitor the prevalence of health risk behaviors among youth.[127] In Nevada, YRBS data are routinely collected from high school and middle school students. Concerningly, Nevada YRBS data show that among students with three or more ACEs, rates of ever taking prescription pain medicine without a prescription or differently than prescribed are high and are similar to rates of ever smoking cigarettes. Among high school students, rates of ever taking prescription pain medicine are higher than ever smoking cigarettes

[117] Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies. "Primary, Secondary and Tertiary Prevention Strategies & Interventions for Preventing NMUPD and Opioid Overdose across the IOM Continuum of Care," (n.d.). Available at: https://cadcaworkstation.org/public/DEA360/Shared%20Resources/Root%20Causes%20and%20other%20research/Crosswalk%20PST_USI_models%20with%20NMUPD_PDO__%20examples_9_27_2016_revised.pdf

[118] State of 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.

[119] Rogers, C. J., Pakdaman, S., Forster, M., Sussman, S., Grigsby, T. J., Victoria, J., & Unger, J. B. "Effects of multiple adverse childhood experiences on substance use in young adults: A review of the literature," *Drug and Alcohol Dependence*, Volume 234 Issue 109407 (2022).

[120] Bryant, D. J., Coman, E. N., & Damian, A. J. "Association of adverse childhood experiences (ACEs) and substance use disorders (SUDs) in a multi-site safety net healthcare setting," *Addictive Behaviors Reports*, Volume 12 Issue 100293 (2020).

[121] Stein, M. D., Conti, M. T., Kenney, S., Anderson, B. J., Flori, J. N., Risi, M. M., & Bailey, G. L. "Adverse childhood experience effects on opioid use initiation, injection drug use, and overdose among persons with opioid use disorder," *Drug and Alcohol Dependence*, Volume 179 (2017), pp. 325–329.

[122] Felitti, V. J., Anda, R. F., Nordenberg, M. C., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine*, Volume 13 Issue 4 (1998), pp. 245–258.

[123] See Note 120 above.

[124] See Note 121 above.

[125] Centers for Disease Control and Prevention. *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*, 2019. Available at: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

[126] Additional results from ACEs and YRBS are included in Appendix D.

[127] Starcevich, K., Zhang, F., Clements-Nolle, K., Zhang, F., & Yang, W. University of Nevada, Reno. 2018 and 2020 Nevada Behavioral Risk Factor Surveillance System (BRFSS): Adverse Childhood Experiences (ACEs) Special Report.

(among high school students, 33.6% ever took prescription pain medicine compared to 31.7% who ever smoked cigarettes).[128]

The Nevada Middle School YRBS is an anonymous and voluntary biennial survey of students in grades six through eight in public, charter, and alternative schools. The 2019 Nevada Middle School YRBS ACEs Special Report compared students' exposure to ACEs to health behaviors across five categories: behaviors that lead to unintentional injuries and violence, tobacco use, alcohol and other drug use, unhealthy dietary behaviors, and physical inactivity. Survey results showed that ACEs exposure was positively correlated to any substance use and substance use before the age of 11 years. Risk of suicide was also positively correlated to ACEs exposure among middle school students. Among students with three or more ACEs, 52% seriously considered dying by suicide, 34.7% made a plan for how they would die by suicide, and 25.5% attempted suicide in the 12 months prior to the survey. A graded dose response between the number of ACEs and likelihood of substance use and other health risk behaviors was present in the results; as the number of ACEs exposure increased, so did the likelihood of engaging in health risk behaviors.[129]

The Nevada Middle School YRBS results showed that among middle school students with three or more ACEs:

- 62.3% ever drank alcohol and 29.8% drank alcohol for the first time before age 11 years
- 34.7% ever used marijuana and 8.4% tried marijuana for the first time before age 11 years
- 29.2% ever smoked cigarettes and 14.9% smoked cigarettes for the first time before age 11 years
- 25.9% ever took prescription pain medicine without a doctor's prescription or differently than prescribed
- 7.3% ever used synthetic marijuana
- 4.9% ever used ecstasy
- 4.7% ever used cocaine
- 3.2% ever used methamphetamines
- 2.5% ever used heroin[130]

Similarly, exposure to ACEs was positively correlated to health risk behaviors, including substance use, among high school students in Nevada. The 2019 Nevada High School YRBS ACEs Special Report described survey data from a random sample of students in 99 high schools. ACEs scores were calculated for 4,939 youth who answered at least one

[128] Maxson, C. Lensch, T., Diedrick, M., Zhang, F., Peek, J., Clements-Nolle, K., & Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2019). 2019 Nevada Middle School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report. https://scholarworks-dev.unr.edu/handle/11714/3254

[129] Maxson, C. Lensch, T., Diedrick, M., Zhang, F., Peek, J., Clements-Nolle, K., & Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2019). 2019 Nevada Middle School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report. https://scholarworks-dev.unr.edu/handle/11714/3254

[130] Ibid.

ACEs-related question. Risk of suicide among high school students was positively correlated to ACEs exposure. Among high school students with three or more ACEs, 38.5% seriously considered dying by suicide, 33.7% made a plan for how they would die by suicide, and 19.7% attempted suicide in the 12 months prior to survey.

The High School YRBS results show that among high school students with three or more ACEs:

- 77.9% ever drank alcohol and 30.5% drank alcohol for the first time before age 13 years
- 56.3% ever used marijuana and 13.3% tried marijuana for the first time before age 13 years
- 33.6% ever took prescription pain medicine without a doctor's prescription or differently than prescribed
- 31.7% ever smoked cigarettes and 12.3% smoked cigarettes for the first time before age 13 years
- 13.5% ever used synthetic marijuana
- 9.9% ever used cocaine
- 8.6% ever used ecstasy
- 4.7% ever used methamphetamines
- 4.5% ever used heroin
- 3.2% ever injected illegal drugs[131]

Impact of ACEs on Adults in Nevada

The Behavioral Risk Factor Surveillance System (BRFSS), established by the CDC, collects data to monitor and assess the prevalence of chronic disease, health risk behaviors, and use of preventive services among adults through a national system of telephone surveys.[132] The Nevada BRFSS is an annual anonymous voluntary telephone survey of adults aged 18 years or older. Like the Nevada YRBS ACEs Special Reports on middle and high school students, the 2018 and 2020 Nevada BRFSS ACEs Special Reports compared exposure to ACEs with health risk behaviors among Nevadan adults.

The BRFSS ACEs Special Report data show that 36.1% of all respondents experienced at least one ACE and 29.9% experienced three or more. Black non-Hispanic respondents (33.3%) and people who identified their race as Other (41.9%) were more likely to experience three or more ACEs compared to white, Asian, or Hispanic respondents. Adults

[131] Maxson, C. Lensch, T., Diedrick, M., Zhang, F., Peek, J., Clements-Nolle, K., & Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. (2019). "2019 Nevada Middle School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report." https://scholarworks-dev.unr.edu/handle/11714/3254

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

ages 18 years to 34 years were more likely to experience three or more ACEs compared to people 35 years and older.[133]

Among adults with three or more ACEs:

- 28.6% reported ever using a prescription pain reliever in a way not directed by a doctor
- 24.9% reported they used marijuana or cannabis in the past 30 days
- 21.5% reported they binge drink
- 21.1% reported they took a prescription drug without a doctor's prescription
- 20.2% reported being current smokers
- 10.1% reported they drank heavily
- 3% reported using any illegal drug, not including marijuana, in the past 30 days[134]

From 2003 to 2020, approximately 53% of Nevadans under the age of 35 years experienced at least one ACE, totaling over 1.7 million aggregate ACEs. It is estimated that 17.3% of Nevada residents ages 0 years–34 years have experienced the ACE of non-recreational opioid misuse by an immediate family member. 38% of all Nevada residents have experienced at least one ACE related to the opioid crisis.[135]

Enhanced supports utilizing evidence-based practices, such as home visitation and strategies to address trauma and ACEs, are necessary for children and families impacted by substance misuse and SUDs including OUD or stimulant use disorder. Growing evidence shows 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 being implemented in Nevada include SUD prevention and treatment, in-home skills-based parenting programs that include skills training, education, and counseling, Kinship Navigator Programs, residential parent-child substance use treatment programs, and developmentally appropriate transition supports with older youth and adolescents.[136]

Additionally, addressing unmet social needs is important to build stability among families. Housing, income, and employment instability worsen risk factors related to substance misuse and SUDs. The 2019 system-wide assessment using SAMHSA's CAST identified that

[133] Starcevich, K., Zhang, F., Clements-Nolle, K., Zhang, F., & Yang, W. University of Nevada, Reno. (n.d.). 2018 and 2020 Nevada Behavioral Risk Factor Surveillance System (BRFSS): Adverse Childhood Experiences (ACEs) Special Report.

[134] Starcevich, K., Zhang, F., Clements-Nolle, K., Zhang, F., & Yang, W. University of Nevada, Reno. (n.d.). 2018 and 2020 Nevada Behavioral Risk Factor Surveillance System (BRFSS): Adverse Childhood Experiences (ACEs) Special Report. https://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/Meetings/5c%20-%20BRFSS%2018%2020%20ACEs%20report_8-17-21.pdf

[135] NRS 433.736. "Requirements and procedures for statewide needs assessment." Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec736

[136] 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.

housing vouchers and affordable housing programs are needed in the Northern and Southern regions of Clark County and Washoe County.[137]

Suicide Prevention

Suicide prevention efforts are an important part of Nevada's overall prevention strategy due to the complex relationship between childhood trauma and ACEs, depression and substance use, and intentional overdose. Nevada has implemented several initiatives to prevent suicide.[138] Two coordinator positions within the Nevada Office of Suicide Prevention were established to collaborate with hospitals throughout the state to initiate the adoption and implementation of Zero Suicide and to begin to introduce the new crisis continuum to communities. The coordinators provided technical assistance to nine of 12 hospital systems from April 2021 to August 2021. They also held Community of Practice meetings monthly to provide formalized technical assistance for participating hospital systems and personalized intensive technical assistance. More work remains to be done to fully implement the Zero Suicide Initiative.

School-Based Education

Preventing opioid misuse among youth is critically important, as early initiation of substance use is a risk factor for developing a SUD.[139] Analysis of adolescent data from the NSDUH from 2004 to 2011 shows that youth initiating non-medical use of prescription opioids at 10 years to 12 years old had the highest risk of transitioning to heroin use in young adulthood, and the most frequently reported initiation age of non-medical prescription opioid use was 16 years to 18 years old.[140]

Alarmingly, drug overdose and poisoning deaths among youth 18 years and younger have increased in Nevada by 550% between 2019 and 2020.[141] During the same time period, nationwide drug overdose deaths and poisonings among children and adolescents have increased by 83.6%. Drug overdose and poisoning is currently the third leading cause of death among children and adolescents in the United States.[142] Rates of illicit drug use among youth in Nevada are slightly higher than the national average, with 8.35% of Nevadan youth ages 12 years to 17 years reporting they used an illicit drug in the past month, compared to 7.71% of youth nationwide.[143] Additionally, compared to the national average, youth in Nevada report lower perceived risk of harm from using cocaine monthly and trying heroin (see Table 5.1).[144]

---

[137] State of 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.

[138] See Note 135 above.

[139] US Department of Health and Human Services, Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, 2016. Available at: https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

[140] Cerda, M., Santaella, J., Marshall, B. D., Kim, J. H., & Martins, S. "Nonmedical Prescription Opioid Use in Childhood and Early Adolescence Predicts Transitions to Heroin Use in Young Adulthood: A National Study," *Journal of Pediatrics*, Volume 167 Issue 3 (2016), pp. 605-12. e1-2.

[141] State of 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

[142] Goldstick, J. E., Cunningham, R. M., & Carter, P. M. "Current Causes of Death in Children and Adolescents in the United States," *New England Journal of Medicine*, Volume 386 (2022), pp. 1955–1956.

[143] Substance Abuse and Mental Health Services Administration. *2019–2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)*, 2021. Available at: https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates

[144] Ibid.

Table 5.1. 2019–2020 NSDUH: Perceived Risk Estimates[145]

	Percentage of those ages 12 years–17 years		Percentage of those ages 18 years and older	
	Nevada	United States	Nevada	United States
Perceive great risk from using cocaine monthly	51.59	53.29	69.3	70.08
Perceive great risk from trying heroin				

In 2017, the Washoe County School District reported that approximately 35% of students in grades nine to 12 lived with someone who misused alcohol, had an alcohol use disorder, or misused drugs.[146] Family history of substance use is a risk factor for high-risk substance use among youth.[147] To reduce substance use-related harms among youth, the Healthier Nevada Youth Educational Modules, a substance misuse prevention curriculum, was created by medical students from University of Nevada, Reno School of Medicine. The curriculum was implemented in the Washoe County School District with students in grades nine to 12 and was designed to educate youth on SUDs, the opioid epidemic, and naloxone.

To assess the impact of the curriculum on students' knowledge and attitudes related to substance use and comfort discussing substance use-related issues with health care providers, a pre- and post-survey was administered. Results from the survey, conducted with 682 students, showed that the curriculum substantially increased students' knowledge and awareness about SUDs, the opioid epidemic, and naloxone. Prior to receiving the curriculum, 65% of students reported their understanding and awareness of naloxone was very poor or poor, and 33% reported their understanding of the opioid epidemic was very poor or poor. Following the presentation of the curriculum, only 6% of students reported their understanding and awareness of naloxone was very poor or poor, and 3% reported their understanding of the opioid epidemic was very poor or poor. Students' comfort level discussing substance use-related issues with healthcare providers also improved following the curriculum presentation. 28% of students strongly agreed they would feel comfortable discussing substance use-related information with their doctor following receiving the curriculum, compared to 19% prior to receiving the curriculum presentation.[148]

In Lyon County, prevention efforts in schools are aided by youth-led peer-to-peer prevention teams, as well as school resource officers, who are also community health workers, as part of their effort to approach treatment and prevention as whole person, integrated care, and to include nutrition and wellness activities as part of prevention and harm reduction. The Healthy Communities Coalition of Lyon and Storey Counties used similar data to other local coalitions of YRBS and community stakeholder data to develop recommendations around local partnerships, local educational efforts in the school and the community on prevention

[145] Ibid.

[146] Rescigno, M., Allen, A., & Meyer, D. "Substance Use and Addiction Education for Northern Nevada Youth," *Pediatrics*, Volume 147 (2021), pp. 222–223.

[147] Centers for Disease Control and Prevention, "High-Risk Substance Use Among Youth," 2020. Available at: https://www.cdc.gov/healthyyouth/substance-use/index.htm

[148] See Note 145 above.

and opportunities for treatment, and the importance of cross-section participation in the coalition and delivering services to the community.[149]

Other school-based prevention opportunities in Nevada have also been identified. The Prevention, Advocacy, Choices, Teamwork (PACT) Coalition identified several prevention needs in Southern Nevada, including engaging students in high-risk environments in after-school programming for youth empowerment, and implementing strategies to reduce binge drinking and drug use among youth ages 18 years to 21 years.[150] Additionally, the 2019 system-wide assessment using SAMHSA's CAST included a review of prevention capacity across several categories, including school-based prevention programs. Among the five regions assessed, only one was rated to have sufficient capacity for school-based prevention programs (Southern Rural Behavioral Health Region).[151]

Public Education

Funding supported by the CDC's Prevention for States program has supported a prescription awareness campaign titled, *Wake up Nevada*. Additional efforts include the Southern Nevada Health District's (SNHD's) OD2A project in collaboration with the PACT Coalition called *Back to Life*, a targeted campaign to reduce naloxone stigma among law enforcement. Several additional opportunities for public education efforts have been identified through local data collection and coalition efforts focused on preventing substance use-related harms. The 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey identified two areas of action in the public education category.[152] Based on survey data, both educational prevention initiatives in the community for youth and providers and community awareness initiatives on how to prevent drug use and misuse and reduce stigma should be implemented in communities. Additionally, the PACT Coalition identified the need to work with cross-system agencies, such as educational institutions, first responders, and law enforcement, to leverage opportunities for community-level change. Efforts noted included developing and strengthening linkages to available resources. Preventing prescription drug use for non-medical purposes, with or without a prescription, was also identified as a priority by the Coalition.[153]

Despite demonstrated needs related to primary prevention programming, public perception supporting the use of State resources to promote prevention appears to be limited according to the 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey.[154] 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.

Provider Education

Safe and appropriate prescribing is also essential to reduce risk of opioid misuse and OUD. In 2018, Nevada's person-level prescribing rates were highest among the older population.

---

[149] Healthy Communities Coalition Lyon and Storey Counties. *Comprehensive Community Prevention Plan 2019–2021*.

[150] PACT Coalition. *2019–2021 Comprehensive Community Substance Abuse Prevention Plan*.

[151] State of 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.

[152] 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.

[153] PACT Coalition. 2019–2021 Comprehensive Community Substance Abuse Prevention Plan.

[154] See Note 151 above.

Nationally, approximately 26.8% of persons 65 years and older had filled at least one prescription for an opioid.[155] The Nevada legislature passed AB 474 in 2018 to address over-prescribing of opioids, resulting in a 39% reduction in prescriptions for opioids and a 56% reduction in co-administration. The legislation also 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 which is subjective. Continued education is needed for prescribers to use or refer to options other than opioids for pain management, such as chiropractic intervention, acupuncture, nerve blocking, and mindfulness and meditation.[156]

SOR grant funding is also being used in Nevada to enhance the skill of prescribers through in-person and online trainings, webinars, and Project Extension for Community Healthcare Outcomes (ECHO) sessions.[157] Project ECHO, currently offered by the University of Nevada, Reno School of Medicine, provides a biweekly clinic on alternative pain management treatments. Topics of the trainings include:

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

Additionally, the Pacific Southwest Prevention Technology Transfer Center (PTTC), funded by SAMHSA, is located at the Center for the Application of Substance Abuse Technologies at the University of Nevada, Reno. The PTTC provides training and technical assistance to substance use prevention, treatment, and recovery organizations in the US Department of Health and Human Services Region Nine. The PTTC is a regional resource that offers information, guidance, training, and technical assistance to increase the adoption of efforts related to preventing substance use-related harms, including opioid misuse and OUD.

Provider Collaboration

Nevada has an ongoing need for collaboration between pharmacists and physicians to reduce misuse of opioids and other prescription medications. One need is the establishment of Collaborative Practice Agreements, allowing all members of a person's care team to use

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

[156] Ibid.

[157] 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.

and share information to improve care delivery. Communication between practitioners can also assist in consolidating information that may be shared by the patient with each practitioner to ensure 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 to obtain prescriptions. 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.

Data Monitoring

The Prescription Drug Abuse Prevention Act, which went into effect on January 1, 2018, implemented a series of requirements that support OUD prevention efforts. The Act requires doctors and hospitals to report drug overdoses to the State, allows licensing boards access to PDMP data to review inappropriate 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 opioid medication.

Additionally, 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 determinants of health (SDOH) factors, such as housing, that play a role in both prevention efforts and treatment outcomes.[158] Data monitoring does not include other important medications, such as gabapentin, and demographic information to better identify those at-risk for misuse.

Community Prescription Drug Disposal

Evidence suggests that prescription drug disposal programs may reduce illicit drug use and unintentional drug poisoning, as well as reduce water pollution.[159] The Churchill County Coalition has planned prescription drug roundups as an initiative, as have many of the other coalitions in the state. Prescription drug drop-off boxes at the Sheriff's Office and lockboxes in the home are common prevention initiatives either in place or planned in Churchill County.[160] The 2019 system-wide assessment using SAMHSA's CAST found that three of five behavioral health regions in Nevada — Northern, Rural, and Southern Rural — were rated to have sufficient capacity in prescription drug disposal events and locations; however, opportunities to grow these programs exist in two regions.[161]

---

[158] State of Nevada Department of Health and Human Services. *Section 1115 Demonstration Waiver: Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project,* 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

[159] County Health Rankings & Roadmaps. "Proper drug disposal programs," 2017. Available at: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/proper-drug-disposal-programs

[160] Churchill Community Coalition. *Churchill Community Coalition Comprehensive Community Prevention Plan*, 2018.

[161] State of 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.

Culturally Centered Prevention Efforts

Applying the Strategic Prevention Framework's principle of cultural competence, prevention programming and efforts should be developed in a culturally centered and competent manner, in partnership with members of the community the intervention or program is intended to reach. The PACT Coalition identified the need for culturally centered prevention efforts in Southern Nevada, especially for Native American communities, LGBTQ+ communities, older adults, and people who speak languages other than English.[162]

Gaps in Primary Prevention[162]

- Community-based prevention programs across all counties, especially for families and youth
- Full implementation of the Zero Suicide Initiative
- School-based prevention programs with measured outcomes that are implemented statewide and are culturally sensitive
- Prescription drug disposal programs
- Patient education on the addictive potential of opioids, and alternative therapies for chronic pain and chronic illness
- Education among high school students around SUDs, awareness of the opioid epidemic, and naloxone use, and attitudes about discussing these topics with health care providers
- Anxiety over seeking help, especially among veterans and tribal members
- Homeless encampment outreach
- Collaborative practice agreements and communication between prescribing providers
- Culturally competent and culturally centered prevention efforts targeted at underserved populations

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

[163] The designation of a gap does not mean the service or program does not exist, but that it is currently insufficient in scope, geographic coverage, resources for sustainability, or populations covered

Gaps in Provider Education

- Education and monitoring with additional metrics and demographic information
- Participation in Project ECHO
- Education of patients on pain management expectations
- Utilization of/referrals to other pain management options
- Pre-treatment screening and care plans that include alternative pain management
- Insufficient screening for SUDs, especially in Medicaid managed care and in rural areas

Secondary Prevention: Identify Opioid Misuse and Potential OUDs Early and Prevent Overdose

The goal of secondary prevention is to reduce the impact of an injury or illness that has already occurred by identifying and treating the condition or injury as soon as possible, preventing re-injury or recurrence, and preventing long-term problems.[164] In the context of OUD, secondary prevention includes early identification of opioid misuse and OUD and preventing opioid overdose. Examples of secondary prevention efforts include addressing stigma and discrimination, Screening, Brief Intervention, and Referral to Treatment (SBIRT), educating people engaged in opioid misuse or who have OUD, and community coalition building, among others.

Addressing Stigma and Discrimination

Stigma and discrimination against people who use drugs and people with SUDs are persistent barriers for individuals seeking services across the continuum of care, including health care, treatment for SUDs, and harm reduction services. Stigma and discrimination also act as systemic barriers that delay or prevent the implementation of evidence-based services for people who use drugs, such as syringe services programs or Opioid Treatment Programs (OTPs).[165] For example, according to the 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey, only 35.2% of respondents strongly agreed or agreed that spending taxpayer money to prevent the misuse of drugs is money well spent.

---

[164] Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies. "Primary, Secondary and Tertiary Prevention Strategies & Interventions for Preventing NMUPD and Opioid Overdose across the IOM Continuum of Care," (n.d.). Available at: https://cadcaworkstation.org/public/DEA360/Shared%20Resources/Root%20Causes%20and%20other%20research/Crosswalk%20PST_USI_models%20with%20NMUPD_PDO__%20examples_9_27_2016_revised.pdf

[165] Tsai, A. C., Kiang, M. V., Barnett, M. L., Beletsky, L., Keyes, K. M., McGinty, E. E., Smith, L. R., Strathdee, S. A., Wakeman, S. E., & Venkataramani, A. S. "Stigma as a fundamental hindrance to the United States opioid overdose crisis response," *PLoS Medicine*, Volume 16 Issue 11 (2019), e1002969.

Despite efforts, many people still report that stigma and the emotional toll it takes on their lives is a major barrier to recovery.[166] 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.

A social media campaign launched in fall 2020 to address community-wide stigma and treatment awareness that will need to be assessed for effectiveness in addressing stigma as a barrier. A new campaign targeting stigma was 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.[167]

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.

Finally, stigma can be a significant problem in healthcare settings, especially among providers who do not specialize in substance use care.[168] The Nevada Minority Health and Equity Coalition reported that many respondents with lived experience reported avoiding seeking necessary healthcare because of the negative, even belittling, treatment they received from healthcare providers.

Screening and Referral for Opioid Misuse

Screening for unhealthy substance use, including opioid misuse, should occur regularly to identify and address risks of OUD and other substance use-related harms early. Nevada offers American Society of Addiction Medicine (ASAM) level 0.5 with no prior authorization, although there is a limit to one screening per 90 days. Nevada notes in its Section 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.

Utilization of SBIRT is necessary for ensuring that people are screened for SUDs, with brief intervention and/or referral to treatment, as appropriate. 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. According to 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 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 MCOs, almost all in Clark County. Rural areas only had 28 total SBIRT claims for the year.[169] There is no evidence that

[166] 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.

[167] State of Nevada Division of Health Care Financing and Policy. *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity,* 2021.

[168] See Note 165 above.

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

adequate screening in primary care and other settings is being accomplished. Such low screening rates indicate a likely underutilization of screening and referral to treatment, therefore, limiting access for those who may not be aware of treatment options.

Screening is only effective when providers know to whom they should refer. A lack of knowledge of available SUD coverage benefits and treatment options has also been cited as a reason providers are not linking consumers to appropriate treatment services. This suggests a lack of sufficient provider education and sensitization on SUDs, treatment options, and benefits, such as through a targeted statewide public education campaign.

Patient Education

Offering people who misuse opioids, are at high risk of OUD, or are in the early stages of OUD prevention education and information is a secondary prevention strategy to reduce and prevent disease progression or other related harms, such as overdose. Tailored education and information interventions for friends and family of people at risk of OUD and overdose can also help to prevent future harms. 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.[170] 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 public and for school systems and providers. One resource is SAMHSA, which provides tools such as the Opioid Overdose Prevention Toolkit[171] that can assist with education and outreach.

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.

Community Coalition Building

Community coalitions that bring together diverse stakeholders are excellent vehicles to help implement the five steps in the Strategic Prevention Framework: assessment, capacity, planning, implementation, and evaluation. Community coalitions can identify specific communities' prevention needs, engage community members in prevention efforts, build resource capacity, and successfully implement prevention programs in a manner that is culturally relevant to the community being served. There are several examples of community coalitions in Nevada that have developed and advanced efforts to prevent and address opioid misuse and OUD-related harms.

The Douglas County's Community Prevention Plan utilized several different data sources, including the YRBS, local suicide completion data, and local data on ED visits and inpatient hospitalizations for SUD and behavioral health to develop a prevention plan that includes

[170] 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.

[171] Substance Abuse and Mental Health Services Administration. *Opioid Overdose Prevention Toolkit,* accessed February 2022. Available at: https://www.samhsa.gov/resource/ebp/opioid-overdose-prevention-toolkit

targeted education interventions. Planned interventions include education to families and individuals needing behavioral health services through health fairs and public media campaigns, education for providers on crisis intervention and trauma-informed care, and public presentations specific to high-risk populations.[172]

The Partners Allied for Community Excellence (PACE) Coalition, serving Elko, Eureka, and White Pines Counties, also used YRBS data, community stakeholder input, and the matrix of Risk and Protective Factors from the National Institutes of Health and the National Institute on Drug Abuse to organize information and set priorities for activities, including prevention and education. Early intervention and prevention efforts present as one of the Coalition's priorities and include engagement such as office space in the Elko County School District to assist the School Resource Officer Program, participation in PACE rural provider meetings from the Head Start of Northeastern Nevada, work with the Head Start in Ely, and work with charter schools in the area. The Coalition has identified the need to improve its relationship with the Great Basin College for prevention efforts. They also fund training and resources for school resource officers, who also provide real-time data on substances seized within schools.[173]

The Join Together Northern Nevada Coalition also used YRBS data and key informant interviews in developing a needs assessment and plan around relapse prevention and community resource deployment. The Coalition formed priorities similar to the other coalitions, including standardized initiatives in schools and inclusiveness in messaging to include community partners, parents, youth, and people who previously used opioids. Plans to do so include programming in school twice a year, workshops about drugs and paraphernalia, and public education campaigns, especially about the dangers of marijuana, which was a key risk in the community. The Coalition noted that funding for opioid campaigns has not been effective, as there is now increased stigma around the use of opioids in the community's perception.[174]

Frontier Community Coalition also found that interventions in the school present an essential part of prevention efforts for Humboldt, Lander, and Pershing Counties. Efforts noted included ensuring that formal parent education classes have recommendations for monitoring children and clear communication with children. Other options noted included exploring opportunities to include parenting messages during events where parents naturally gather, such as sporting events and school orientation, as well as documenting that opportunities for a more significant number of children to become involved with peers in a positive social setting, and working toward a common goal will reduce substance abuse rates. Also of note was a desire of surveyed stakeholders for opportunities to visit larger communities to help young people understand where they may fit into the larger world and help them set future goals, as was collaboration with school districts to support tutoring programs to help increase academic performance. Another item of note was to organize alcohol-free events to help people create positive connections with one another and for youth to see positive examples of adult behavior.[175]

---

[172] Partnership Douglas County. *Douglas County's Community Prevention Plan 2019*.

[173] PACE Coalition Serving Elko, Eureka, and White Pine. *Comprehensive Community Prevention Plan 2020–2023*.

[174] Join Together Northern Nevada. *Comprehensive Community Prevention Plan for Washoe County 2020–2022*.

[175] Impact and Frontier Community Coalition. *Comprehensive Community Prevention Plan 2020–2023*.

The CARE Coalition also identified education and targeting youth as critical components in an effective prevention program, as youth are one of the most vulnerable populations for substance use, especially marijuana. They also noted a lack of funding as a barrier to deliver prevention services effectively. The Coalition suggested reaching out to specific agencies willing to assist in substance misuse prevention for direct funding. State and grant funding may require a greater lift for application and wait time to receive funds. Increased partnership with other agencies to address SDOH, such as housing and transportation, was noted as a priority, as was providing education and resources to vulnerable populations such as LGBTQ+ individuals, Native Americans, and the elderly, in addition to the youth population.[176]

The Churchill Community Coalition also found that a community-wide system of programs and services were a key resource in the Coalition's prevention plan for Churchill County.[177] The Coalition flagged the need to support research-based programming with the goal of reducing risk factors and increasing protective factors. Education and marketing also presented as tools for prevention planning, including a counter/truth marketing campaign to "glamorize and reaffirm teen sobriety is the norm."

Similar results were found by the Nevada Minority Health and Equity Coalition report from forums and interviews with 51 people with lived experience.[178] Not only did people in more rural areas report less knowledge of the risks of prescription opioids and recovery resources, but family members of people who were in treatment experienced a great deal of anxiety due to a lack of understanding 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 to combat stigma. Encouragement and a sense of community were felt to be necessary for the public to better respond to addiction and decrease stigma.

[176] CARE Coalition. *Comprehensive Community Action Plan*. 2019

[177] Churchill Community Coalition. *Churchill Community Coalition Comprehensive Community Prevention Plan*, 2018.

[178] 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.

Gaps in Secondary Prevention[179]

- Broad adoption and implementation of SBIRT models, including in primary care and other community-based health care settings
- School-based secondary prevention
- Trainings for people and their family members who use or misuse opioids and/or have experienced a nonfatal overdose, including overdose prevention and reversal strategies
- Programs to decrease stigma among medical providers
- Programs to decrease stigma among community members likely to interact with people in recovery
- Statewide programs to address stigma in the public
- Education on treatment options for OUDs
- Education for family members on treatment of OUDs

Tertiary Prevention: Reducing Harm and Restoring Health

Tertiary prevention involves limiting harm from substance dependence through effective rehabilitation and long-term aftercare. Tertiary prevention is generally offered through specialized outpatient or residential programs focused on restoring a person's health to the most optimal level that can be achieved and is then maintained through sustained supports over time. This section is primarily focused on harm reduction efforts while specialized outpatient and residential services are discussed in the prior section regarding access to treatment.

Community Perceptions Regarding Harm Reduction

Fifty-one individuals from Nevada participated in a Community-Based Participatory Research (CBPR) project by Nevada Minority Health and Equity Coalition, as one of the requirements for this Needs Assessment in SB 390.[180] CBPR is a unique framework for gathering information from those in the community with lived experience, ensuring 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 they found harm reduction resources useful. However, barriers in urban areas included limited

[179] The designation of a gap does not mean the service or program does not exist, but that it is currently insufficient in scope, geographic coverage, resources for sustainability, or populations covered.

[180] 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.

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 public and from law enforcement, and lack of education on the addictive potential of opioids, and alternative therapies for chronic pain and chronic illness.

Harm Reduction Resources

Syringe Service Programs

Nevada has made progress in Integrated Opioid Treatment and Recovery Centers (IOTRCs), which build services around individuals, allowing for a more integrated care model that addresses SDOH and other comprehensive treatment needs.[181] Other innovative practices in harm reduction 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. 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 needle exchange capacity is low relative to need in all regions of the state.[182] 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. However, respondents of the survey did not link needle exchanges with positive outcomes. 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. Nevada needs both expanded syringe exchange programs and efforts to educate the public on the true impact and benefit of such programs.

Peer Supports for Harm Reduction

Peer supports are an essential component of tertiary prevention and recovery programs for SUDs. Peer supports promote 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 underserved populations and promote an increase in cultural competency through their lived experiences. Expansion of peer supports would allow for greater outreach to individuals living with SUDs, although implementation especially

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

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

in rural and frontier areas can be challenging due to lack of available providers and programming.[183]

Overdose Reversal

The Nevada Rural Opioid Overdose Reversal grant provided Desert View Hospital and five other critical access hospitals, Project ECHO Nevada, Nevada Rural Hospital Partners, and DHHS the resources needed to train emergency medical providers on the administration of naloxone after SB 459 authorized its use by first responders.[184] Opioid State Targeted Response (STR)/SOR grants have funded naloxone and overdose education for first responders.

Naloxone is currently available without a prescription, and community-based organizations can distribute naloxone for free. Nevada, in partnership with Salesforce, implemented an innovative naloxone inventory management program, the Naloxone Virtual Dispensary, that ensures that naloxone is available statewide. Naloxone is funded primarily through federal grants. It is required to be available at all Integrated Outpatient Treatment and Recovery Centers and Certified Community Behavioral Health Centers. The State has also successfully collected data on naloxone distribution, including to whom naloxone is being distributed. In 2018, Nevada developed a provider's guide to prescribing naloxone.[185] Nevada has made great strides in ensuring naloxone is available and that providers and first responders know how to use it. However, a survey of people with current or past OUD identified that individuals in the community, especially those experiencing homelessness, need more education about naloxone and how to use it.[186]

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

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

[185] State of Nevada Division of Public and Behavioral Health. *Naloxone for Opioid Safety: A Nevada Provider's Guide to Prescribing Naloxone to Patients Who Use Opioids,* 2018. Available at: https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/opioids/naloxone_toolkit_color.pdf

[186] 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.

Gaps in Tertiary Prevention and Harm Reduction[187]

- Limited hours of operation for harm reduction services
- Community education for the use of Naloxone
- Education on harm reduction resources and methods in rural areas
- Privacy from the public and from law enforcement when using harm reduction resources, especially in rural areas
- Education in encampment communities
- Needle exchange capacity is low relative to need in all regions of the state
- Prohibitive prior authorization requirements for peer recovery support services

Treatment of OUD

Access to treatment and service utilization can be difficult to measure statewide across all payers, and particularly hard to estimate for special populations, such as those living in underserved communities, pregnant women, transition-age youth, people experiencing homelessness, and others who might experience disparities. Until Nevada establishes its multi-payer claims database, reliable information on the number of people with SUD or OUD diagnoses and/or receiving treatment is limited. Most gaps in treatment reported in this Needs Assessment summary are identified through the CAST results and Medicaid data provided by the Nevada DHHS Office of Analytics. Overall, the CAST identified a 70% unmet need/insufficient capacity of services statewide.[188]

Treatment availability was found to be the most significant and critical need for residents with OUDs across the state.[189] A July 2019 report estimated that 400,000 Nevadans who need substance use treatment in a year do not receive it.[190]

Trends in Nevada Medicaid have identified an overall increase in SUD service utilization. The number of Medicaid members with SUD claims has steadily increased from 44,275 in 2017 to 79,940 members in 2020.[191] Of the 79,940 members, 27% had claims related to OUD. The highest numbers of members with claims related to OUD were members 25 years–34 years old. However, as of 2018, only 31.5% of those with an SUD diagnosis received treatment or

[187] The designation of a gap does not mean the service or program does not exist, but that it is currently insufficient in scope, geographic coverage, resources for sustainability, or populations covered.

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

[189] State of 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.

[190] See Note 187 above.

[191] Data received from the State of Nevada Department of Health and Human Services Office of Analytics, January 7, 2022.

recovery services, indicating a lack of access or engagement despite an increase year to year.[192]

Statewide from 2015 to 2020, the number of individuals diagnosed with an OUD increased from 7,050 to 16,433 (a 133% increase).[193] Of those individuals diagnosed with an OUD, those who received outpatient treatment increased from 37% to 47%. This increase could be due in part to the expansion of Medicaid eligibility in 2014, in addition to overall increases in opioid use over recent decades. People of American Indian and Alaskan Native ethnicity account for 1.1% to 1.3% of OUD diagnoses, 0.3% to 0.5% of those in outpatient treatment, and 0.1% to 0.2% of those on MAT, indicating an underutilization of outpatient services.

Trends are difficult to identify because recent data reflect utilization during the COVID-19 PHE restrictions, as mentioned in the prior section. Treatment utilization in Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) facilities specializing in SUDs fell by 31% between 2019 and 2020, likely due to COVID-19 restrictions and concerns in the community about the transmissibility of the virus. Not only has the PHE exacerbated mental health and substance use issues, it has also likely contributed to a pent-up demand now that vaccines are available and treatment providers have increased their in-office availability.

General Treatment Issues

Special Populations and Health Equity

Minority Populations

Nevada is currently lacking sufficient data to draw strong and actionable conclusions about disparities in access and treatment for minority populations. However, Medicaid data suggests decreased treatment for Hispanic and Black Nevadans. Approximately 84% of Medicaid members receiving SUD and OUD services were white, 9% were Black, 1% were American Indian/Alaskan Native, and 15% identified as Hispanic. Since Black Nevadans make up 12.1% (versus 9% receiving treatment) of the total population and Hispanics 28.7% (versus 15% receiving treatment), there is likely a significant disparity based on available data.[194] It is not clear why such disparities might exist.

Although Nevada-specific statewide data is not available, literature reviews and national data suggest significant disparities for racial/ethnic minority youth. In a national study, Black youth with SUDs reported having received fewer specialty services.[195] Both Black and Hispanic youth reported receiving fewer informal treatment supports due to several possible factors involving providers, environmental context, and community resources.

Health disparities are likely a significant gap. 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

[192] See Note 187 above.

[193] Data received from the State of Nevada Department of Health and Human Services Office of Analytics, January 7, 2022.

[194] Ideally these comparisons should be made within the Medicaid population rather than comparing treatment within Medicaid to the entire population.

[195] Alegria, M.I., 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).

by DHHS to continue to build health equity, which will need to be based on strong and informative health equity data.

American Indian/Alaskan Native Populations

Nevada has 27 federally recognized tribes, with 32 reservations or colonies.[196] 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. All these factors tend to increase the likelihood of health disparities.

The health care delivery system for Nevada and parts of Utah and Arizona are overseen by the Phoenix Area Indian Health Service (PAIHS).[197] The system includes healthcare facilities operated by local tribes and AI/AN health programs and encompasses primary care, tertiary care, and specialty services. PAIHS is leading numerous behavioral health-related initiatives. Four health facilities or service units offer either purchased/referred treatment in the local community (Schurz Service Unit) or directly provided treatment in the community that involves some level of substance use-related interventions. There are also two substance use treatment facilities, one of which is for males aged 12 years–18 years.

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 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 Statewide Tribal Consultation on request and maintains relationships with organizations currently distributing naloxone to their communities.[198] 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.

The SOR II Tribal Needs Assessment found that there are no mutual support meetings (e.g., Alcoholics/Narcotics Anonymous) in Las Vegas or Northern Nevada that are AI/AN-specific or located in tribal locations. They did find that Elko, Garnerville, and Owyhee communities near tribal areas did have meetings available.[199] Additionally, only four of the 14 Indian Health Service clinics have a practitioner who is DATA 2000 waivered. Residents of other areas without waivered providers need to drive long distances to receive MAT treatment.

---

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

[197] Ibid.

[198] 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.

[199] Ibid.

Pregnant Women

Pregnant women in Nevada are 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.[200] 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. During the June 2022 meeting of the ACRN, a provider of comprehensive specialty services for pregnant women reported that their services are underutilized, likely because of stigma in the community, both on the part of referral sources and individuals needing treatment.[201]

Youth

Programming targeted to young adults and transition-age youth is lacking. There is only one facility for youth treatment in the state outside of the PAIHS. Additionally, adolescent beds, certified to treat co-occurring disorders, are lacking. Nevada currently ranks number 51 in the nation among states and US Territories for the prevalence of mental health disorders and access to treatment.[202] SAPTA performed a needs assessment and found there is a critical need for treatment for youth with co-occurring disorders, especially for inpatient facilities, as there is only one in the state that treats youth, making this a difficult service to access for both youth and their families.[203]

The University of Nevada, Reno School of Social Work was awarded a grant to train primary care and other providers on key elements needed to work with children, adolescents, transition-age youth, and their families.[204] However, shortages of providers to treat substance use in youth remain and are especially problematic in rural areas. A 2019 Nevada DHHS survey found that state- and community-level stakeholders prioritized young adults and transition-aged youth as among the highest risk for substance use.

While data on youth treatment and follow-up in the juvenile justice system in Nevada is sparse, one national study found that about half of the youth who had been in detention did not receive needed treatment for substance use.[205]

Rural and Frontier Nevada Residents

Rural and frontier areas are greatly impacted by the lack of local treatment programs while also experiencing higher rates of youth alcohol use, opioid prescribing, and prescription-related overdose deaths. The State is investigating the purchase of mobile RVs to increase the presence of MAT opportunities in high-need communities. 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

---

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

[201] State of Nevada Department of Health and Human Services. "Advisory Committee for a Resilient Nevada (ACRN)." Available at: https://dhhs.nv.gov/Programs/Grants/Advisory_Committees/ACRN/Home/

[202] See Note 199 above.

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

[204] Ibid.

[205] Welty, L., Harrison, M., Abram, K., et. Al. "Health Disparities in Drug and Alcohol-Use Disorders: A 12-year Longitudinal Study of Youths After Detention," *American Journal of Public Health*, Volume 16 (2016), pp. 872–880.

treatment, only exacerbates the disparity. The Nevada Infrastructure Assessment Report summarized that rural and frontier residents have "little to no access to mental health services."[206]

Services for Co-Occurring Mental Health and SUDs

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 number 42 compared to all other states for low access to care and high prevalence of mental illness in adults.[207] For youth, Nevada is ranked number 51 in the country for mental health prevalence and treatment access.

SAMHSA reports that over a third of people who seek treatment for opioid use have a co-occurring mental health diagnosis.[208] Additionally, 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.

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 SAPTA offers certifications to providers who meet specific criteria for treating co-occurring disorders, with 108 such certified facilities for adults and only 39 for adolescents. This type of certification can help individuals identify treatment providers who will better meet their needs.

However, according to numerous reports, there are still not enough of these certified providers to meet community needs. The Nevada Minority Health and Equity Coalition qualitative study noted that respondents with lived substance abuse experience reported the need for more mental health treatment during and after MAT to improve recovery outcomes.[209] A State needs assessment also identified the critical need for the treatment of youth with co-occurring disorders. [210]

Finally, 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 OUDs will not be as effective if treatment protocols for co-occurring use of stimulants and other substances are not a part of an integrated treatment approach.

Evidence-Based Care

While access to treatment is essential, it is also important that the treatment available be evidence-based and oriented toward evaluating outcomes for treatment recipients. Nevada

---

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

[206] Mental Health America. "The State of Mental Health in America," 2021. Available at: https://mhanational.org/issues/state-mental-health-america

[206] Ibid.

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

[209] 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.

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

lacks a standard measure or monitoring capability to ensure treatment across all settings is delivered according to evidence-based standards and that outcomes are tracked. Training in and implementation of evidence-based models is mainly left to the discretion of individual providers and agencies. However, Integrated Outpatient Treatment and Recovery Centers and Certified Community Behavioral Health Clinics are comprehensive treatment provider types that are required to have training in evidence-based practices and monitor outcomes.

Discharge and Transition of Care

The 2020 Medicaid data 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.[211] 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. The downward trend in the second quarter is consistent with the timing of the COVID-19-related PHE restrictions and the associated drop-in outpatient services. For Medicaid FFS, which is mostly in 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, readmissions among beneficiaries with a SUD totaled 1,933 among FFS Medicaid and 2,732 for Medicaid members in managed care. This data should be carefully interpreted due to the timing of the COVID-19 PHE. It generally supports the need for better discharge planning and transition for the SUD population.

Qualitative data also supports this need. The 2021 study of people with lived experience with opioids reported a significant need for better coordination among different levels of treatment programs and better supports upon discharge back to the community.[212]

Workforce Shortages

The National Drug Helpline cited factors contributing to the risk of overdose fatalities, such as reduced access to treatment programs, including EDs, and lost healthcare capacities due to staff falling sick, among others. The COVID-19 PHE has amplified the workforce shortage across sectors. 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.[213] All but one of Nevada's counties (Washoe) are designated Mental Health Professional Shortage Areas.

Workforce shortages present a key risk factor for individuals seeking treatment. Federal data from 2021 indicates that over 2,445,000 Nevadans live in designated mental health care Health Provider Shortage Areas (HPSAs), with 52 HPSA designation areas as measured by available psychiatrists.[214] Only 35.4% of the estimated need for mental health providers is

[211] Data received from the State of Nevada Department of Health and Human Services, April 2022.

[212] 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.

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

[214] Kaiser Family Foundation. "Mental Health Care Professional Shortage Areas (HPSAs)," accessed for September 30, 2021. Available at: https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22desc%22%7D

currently being met, with 111 additional providers needed in order to remove the HPSA designation.[215] HRSA estimates that by 2030, the national supply of adult psychiatrists will decrease by 20%, which indicates a trend in the wrong direction compared to Nevada's needs.[216] Additionally, 100% of all Nevada counties (except Washoe) are designated mental health care shortage areas, again as pertains primarily to psychiatrists.[217]

While nationally, the average number of SUD providers is 32 per 1,000, Nevada currently averages 11 providers per 1,000.[218] HRSA estimates that by 2030, the national supply of addiction counselors will only increase by 3%, and demand is expected to increase by 15%.[219] The lack of providers presents challenges when individuals attempt to access services and support.

With more providers also concentrated in urban areas, access limitations experienced by rural residents are even more pronounced. At the June 2022 ACRN meeting, one rural community leader reported that rural areas lack paid internship opportunities that would not only keep local residents in the areas as they train and work but promote more people choosing to work in behavioral health because they do not have to relocate to complete their training.[220]

CAST results indicated a significant shortage in outpatient treatment capacity for psychiatrists and psychologists throughout Nevada.[221] Northern and Rural Behavioral Health Regions reported significant deficits in licensed counselors. The CAST report suggested that the shortages varied by region, with poverty and insurance status limiting available providers in urban areas and distance to providers/provider availability limiting capacity in rural and frontier areas.

Telehealth

Telehealth offers opportunities to close some of the gaps in access to care in rural and frontier areas if those areas have access to technology and internet service in their homes or nearby. Nevada providers and other entities have awarded numerous federal grants to strengthen telehealth infrastructure.[222]

Nevada is considered to have progressive telehealth regulations.[223] AB 181, filed in September of 2020, ensures that any insurer or other organization providing health coverage through Medicaid provides benefits for mental health or SUDs at fair coverage as that of medical and surgical needs. SB 5, effective October 1, 2021, has instituted the requirement that telehealth data is collected and analyzed to improve equity. The federal SUPPORT Act

[215] The calculation of HPSA is primarily based on psychiatrist availability, not on other mental health providers such as psychologists, clinical social workers, psychiatric nurse practitioners, and marriage and family therapists.

[216] Health Resources & Services Administration Health Workforce. "Behavioral Health Workforce Projections," accessed April 2022. Available at: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health

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

[218] Ibid.

[219] See Note 215 above.

[220] State of Nevada Department of Health and Human Services. "Advisory Committee for a Resilient Nevada (ACRN)." Available at: https://dhhs.nv.gov/Programs/Grants/Advisory_Committees/ACRN/Home/

[221] State of 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.

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

[223] Ibid.

Section 2001 now allows people covered by Medicare to receive telehealth services in their homes rather than having to travel to a facility. This incentivizes more providers to continue or expand their telehealth services, benefiting the rural and frontier communities. Telehealth in Nevada is a strength that could be built upon to bolster treatment access in all areas of the state. COVID-19 flexibilities further promoted the use of telehealth, with the additional benefit of increasing access in rural communities through suspension of the telephonic restrictions, allowing telehealth for group therapy and allowing people to receive telehealth in their homes.

Outpatient Treatment

Certified Community Behavioral Health Clinics

Nevada is expanding its Certified Community Behavioral Health Clinic (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 outpatient services that can fill gaps in the service system, including opioid treatment, physical and behavioral health care integration, and 24/7 crisis services. The CCBHCs are expected to improve the quality of community-based treatment through attention to data-based outcomes and monitoring and additional training requirements in best practice treatment models. However, currently, the CCBHCs do not cover every geographical area. Many providers are relatively new to this model, so over time, the impact on individuals with OUD is likely to increase as they gain more experience and more clients.

IOTRCs

The State has built a hub-and-spoke infrastructure through IOTRCs. Nevada has three hubs with nine locations and more than 190 spokes serving the counties of Clark, Washoe, Elko, and Carson City. More than 4,000 patients are receiving OUD treatment and recovery support services through this system.[224]

IOTRCs provide regional expertise and comprehensive outpatient services, including MAT, referral to community resources, care coordination, and recovery supports. IOTRC hubs can only be Federally Qualified Health Centers (FQHCs), CCBHCs, and OTPs.[225] The intent for IOTRCs is that individuals need to come to the central hub on a minimal basis while receiving MAT, with other treatment and support resources at the spokes of the hub frequently utilized. The spokes will be in more areas, making it more likely that they will be closer to the individual's home to make adherence to treatment accessible where issues such as childcare or transportation may present a challenge.

While IOTRCs play an essential role in improving access, reports indicate that there may not be sufficient spokes in rural and frontier areas and that reimbursement and overall infrastructure need to be enhanced.

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

[225] State of Nevada Division of Health Care Financing and Policy, *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity*, 2021.

MAT

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.[226] 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. OTP and Office-Based Opioid Treatment (OBOT) services are not widely available in rural and frontier areas, in part, because the volume of the population in these areas is too small to sustain brick-and-mortar programs and to indicate a need for IOTRC expansion.

Opioid Treatment Programs

Nevada has 15 OTPs offering MAT in outpatient settings, but only in Clark, Washoe, and Carson City Counties, leaving 13 counties without any OTP.[227] In a state survey, most OTPs reported that they have additional treatment capacity, 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.

Office-Based Opioid Treatment

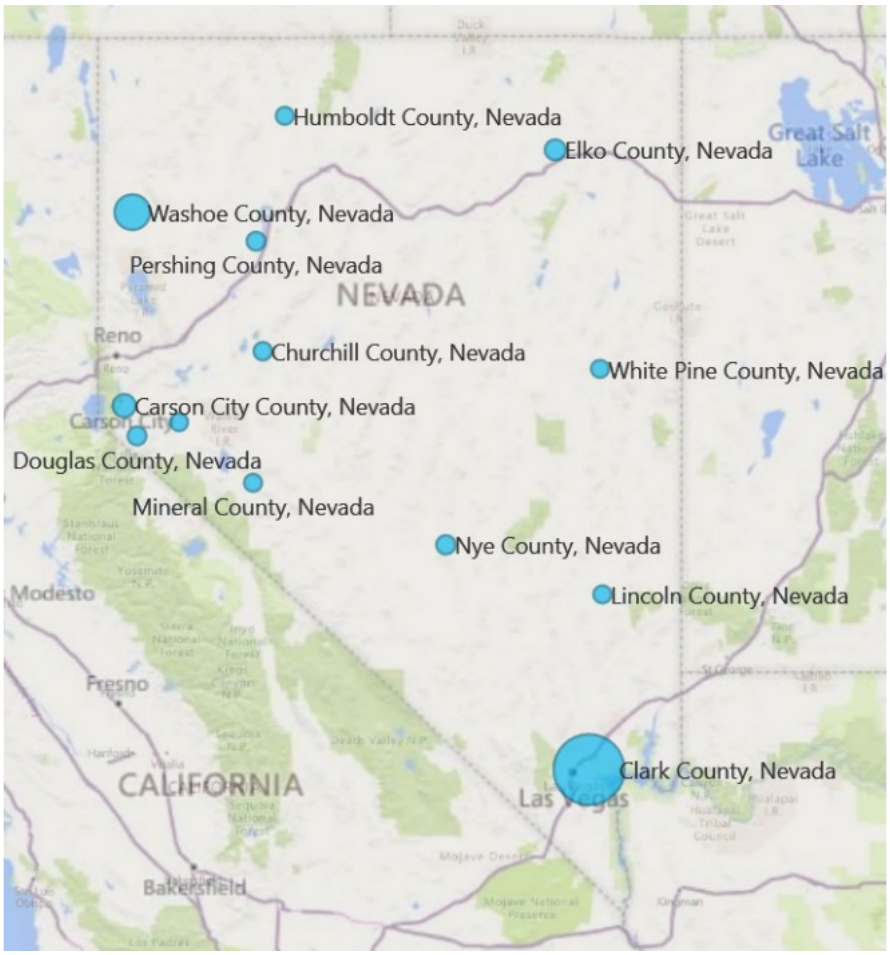
Thirteen counties in Nevada have OBOT. Only Nevada's urban areas, Carson City, Clark, and Washoe Counties, have more than 10 providers, and eight of the 13 counties have fewer than five providers.[228] Nevada's analysis of OBOT providers found that only a few of the OBOT providers were prescribing up to their DATA 2000 waiver capacity. The most significant barriers to serving more people were reimbursement, lack of time, and referrals. In addition, only about one-fourth of the OBOTs that responded to the State's survey reported offering counseling, which is a best practice for MAT. Additionally, at least part of every county in Nevada is designated as a HPSA, so the baseline availability of providers who could potentially become DATA 2000 waivered is lacking.

[226] 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.

[227] See Note 223 above.

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

Figure 6. Distribution of OBOT[229]



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

Gaps in Outpatient Treatment[229]

- Data on equity and disparities in treatment outcomes for racial and ethnic minorities
- Provider availability for pregnant women with OUD
- Treatment/provider availability for individuals with co-occurring disorders, especially youth, and serving youth in inpatient and residential facilities
- Access to mental health care as compared with disease prevalence and demand for treatment
- Residential and outpatient MAT programs in rural and frontier areas
- Transportation to treatment and recovery supports, especially in rural and frontier areas and for non-Medicaid populations
- Withdrawal management services with seamless transfer to treatment after detoxification
- Utilization of existing OTPs to capacity
- Availability of OTPs in most counties
- OBOT in rural and frontier areas
- Counseling for individuals receiving OBOT
- Psychiatrists and psychologists specializing in SUD psychotherapy
- Outpatient detoxification and licensed drug and alcohol counselors in rural regions
- MAT and other treatment interventions in justice facilities
- Evidence-based treatment protocols for those using multiple substances and for those with co-occurring mental health and physical health disorders

Inpatient, Residential, and Detoxification/Withdrawal

Higher levels of care, such as inpatient, 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 as lacking capacity relative to need in all regions of the state.[231] In June 2021, the State reported having 929

[230] The designation of a gap does not mean the service or program does not exist, but that it is currently insufficient in scope, geographic coverage, resources for sustainability, or populations covered.

[231] State of 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.

licensed residential and withdrawal management inpatient/residential beds classified as Institutions for 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 years, due to their classification as IMDs under federal regulations.[232] In the absence 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, resulting in higher crisis utilization.

In 2021, Nevada's plan to address significant gaps in the substance use system through the 1115 waiver for SUD services was submitted for approval to CMS.[233] The pending waiver includes adding 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). Currently, 86% of Nevada's withdrawal and inpatient resources are not reimbursable by Medicaid because of the federal IMD exclusion. The waiver also opens the 929 IMD beds for Medicaid payment for an average stay of 30 days for beneficiaries between the ages of 22 years–64 years, a previously excluded benefit for IMDs, and provides case management for beneficiaries in IMD facilities which 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. While the release only affects care funded by Medicaid, expanded funding for these services is likely to result in better sustainability and growth options for those already established.

Although 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 and is mostly focused on Medicaid beneficiaries. 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.

[232] State of Nevada Department of Health and Human Services. *Section 1115 Demonstration Waiver Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project,* 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

[233] Ibid.

Gaps in Inpatient, Residential, and Detoxification/Withdrawal

- Short- and long-term rehabilitation in all regions of the state
- Funding for withdrawal and residential treatment beds for Medicaid beneficiaries (ages 22 years–64 years) and the uninsured
- Supports for people who have completed detoxification but are awaiting treatment
- Short-term rehabilitation (< 30 days) and long-term rehabilitation (30+ days) statewide
- Access to inpatient, residential, and withdrawal management services in rural areas
- Funding for infrastructure to expand withdrawal and other levels of care

Crisis Services

In addition to inpatient and outpatient, 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. 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.[234] One indicator of the need for better community-based crisis response capacity is ED utilization for substance use problems, which are not best addressed in that setting. Most recently, Medicaid data from the first quarter of 2021 shows a rate of 352.1 per 1,000 FFS beneficiaries and 408.4 under managed care. [235] 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 to decrease some of the ED utilization for substance use and increase crisis response capacity.

In addition to mental health and substance use comorbidity, opioid use alone creates crises that can be addressed by the behavioral health crisis system. Along with the work accomplished to implement 988 by the summer of 2022, and implementation of crisis stabilization units (CSUs), expansion of mobile crisis teams that are trained in harm reduction and can carry naloxone are also essential to addressing the opioid crisis.

9-8-8 Crisis Hotline

As recommended by SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit,[236] Nevada has done a great deal of work to assess and improve the current crisis system. Planning is underway for the State's new 988 framework, for a consistent evidence-based model for mobile crisis that includes a multi-disciplinary team of clinicians and peers and 24/7 in-person response, and for CSUs. 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

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

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

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

and targeted to children and adolescents that have the ability to dispatch specialized child mobile crisis teams 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 911 for co-response with law enforcement. Nevada is progressing in its system by planning for a more robust 988 service that is comprehensive, a single point of contact for behavioral health crisis, and can potentially dispatch mobile crisis teams across the state. The crisis line is intended to address both substance use and mental health crises.

Mobile Crisis Teams

Nevada's CCBHCs fill 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, along with additional resources, to the whole community should help decrease ED utilization and help those in a SUD-related crisis to connect to treatment and recovery resources. However, Nevada's CCBHCs are in various stages of refinement of their mobile crisis teams, are not yet serving their communities to the capacity needed, and are not uniformly covering rural and frontier areas. Therefore, Nevada lacks a consistent and coordinated, in-person, evidence-informed 24/7 statewide mobile crisis response system. Such a response system is essential for saving lives in overdose situations, as well as ensuring people receive appropriate follow-up care.

Nevada has some innovative mobile crisis-type teams, including child mobile crisis teams that can respond in person in Reno and Las Vegas. However, their capacity is limited and backed up by telephonic crisis line resources. Rural areas of Nevada have access to telephonic and tele-video crisis care for adults and children, but the intervention 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. 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.[237]

Las Vegas has a unique ambulance-based mobile crisis model through Las Vegas Fire and Rescue that is available only in a specific downtown area and is available nearly 24 hours per day. Due to the paramedics' advanced scope of practice, transportation can be offered directly to behavioral health facilities rather than going through an ED for medical clearance, but it is limited in capacity. Reno has recently implemented a similar program.

Overall, the current in-person response resources have limited capacity to respond quickly and robustly to everyone in their local communities. Some current in-person crisis teams (CCBHCs in particular) 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

[237] 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.

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 increase education to the community about this resource, providers of mobile crisis may need assistance increasing their own capacity to respond. Additional staff, which is difficult to find due to workforce shortages, training, and adjustment to a "firehouse model" where staff is 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 its mobile crisis system and included the requirement that peers be an essential part of mobile crisis teams.[238] Therefore, more peers will be necessary to help staff these teams than the State currently has available.

Crisis Stabilization Units

Nevada is currently working on developing and expanding CSUs, the "somewhere to go" element of the Crisis Now model of comprehensive crisis services. Ensuring these units can serve individuals with OUDs is essential for rounding out the mobile crisis response system. CSUs only exist in urban areas, and they offer one bed per 100,000 residents rather than the recommended three beds per 100,000 residents. Urban areas have the infrastructure to expand to the recommended three beds per 100,000 residents likely needed to serve local residents.[239] 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.

Secure Behavioral Health Transportation

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.[240] However, as of the publication date of this report, no providers have been certified to provide this service, although a few are in the application process.

[238] Senate Bill 390. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Text

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

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

Gaps in Crisis Services

- Statewide, consistent and coordinated, in-person, 24/7 mobile crisis response system
- Single point of contact for behavioral health crises
- Dispatch independent mobile crisis teams through central crisis call center
- Mobile crisis teams that are trained in harm reduction and carry naloxone
- CSUs, especially accessible to rural and frontier areas
- Staffing for crisis system

Treatment in Criminal Justice Settings

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.[241] Although progress has been made through drug treatment courts and similar interventions, these opportunities are not uniformly available in all criminal detention centers.

Drug Courts

Drug courts can improve 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. Youth offender and reentry 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 to allow judges a full picture of the needs of the individual and to 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.[242] 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.

Reentry and Post-Release

Engagement during incarceration is crucial, as individuals incarcerated are in a forced state of abstinence and, therefore, are more likely to relapse and overdose upon release. A warm handoff makes a significant difference, as does the education of and the relationship with

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

[242] Nevada Overdose to Action and University of Nevada School of Community Health Sciences. *Nevada's Overdose Landscape Presentations*, July 7, 2021.

parole and probation officers about the needs of an individual struggling with substance use upon release.

Insufficient support upon reentry presents a leading cause of relapse and opioid overdose. Among Hispanic Nevadans who died of opioid overdoses, 5% had been recently released from the criminal justice system.[243] 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.[244] The survey concluded that there is a significant need for transitional and clinical services for the justice population, citing 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. Washoe County and Mineral County jail facilities have implemented a program for naloxone distribution upon release, and Washoe County provides naloxone to parole officers trained in harm reduction. However, these programs are not statewide, and consistent warm handoffs with the community are still needed.

Public Perception of Justice-Based Interventions

The 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey, which included 669 respondents, included questions regarding public perceptions of drug misuse and justice involvement.[245] 79% of the respondents agreed or strongly agreed that youth who use drugs are likely to commit crimes, and 54.9% of respondents agreed or strongly agreed that nonviolent 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 nonviolent minor crime. Only 48.7% agreed or strongly agreed that treatment should be available to all individuals who misuse drugs. This data highlights the need for public education and sensitization to the importance and impact of treatment and prevention services for individuals re-integrating into the community post-incarceration. Without public support, funding to fully implement these important programs will be difficult to obtain.

[243] Larson Institute/Nevada Overdose to Action. *2020 Hispanic/Latinx Overdose*, 2021.

[244] 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.

[245] 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.

[246] The designation of a gap does not mean the service or program does not exist, but that it is currently insufficient in scope, geographic coverage, resources for sustainability, or populations covered.

Gaps in Treatment in the Criminal Justice System[245]

- Post-release bridging services to offer engagement during incarceration and transitional support into the community
- Knowledge base of probation/parole offices on the needs of individuals on release/community reentry regarding treatment support options and harm reduction
- Statewide availability of drug courts and transitional/reentry services and supports ranging from treatment to housing
- Public support for treatment and prevention services for individuals re-integrating into the community post-incarceration
- Access to MAT and other treatment interventions within the jails and prisons

Recovery Supports

A Recovery Oriented System of Care "…is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems."[247] Recovery supports are an essential component of relapse prevention, as well as for good treatment engagement and outcomes. Overall, Nevada's 2019 assessment identified that the category of recovery has a 63% unmet need/insufficient capacity statewide.[248]

Recovery supports vary greatly by region, as they are often less structured, less formal, and tailored to individual support needs. There are several recovery resources funded by grants and State funds across the state.[249] Foundation for Recovery offers outreach in several settings, including women in Washoe County Corrections, local and rural hospitals in Northern Nevada, and in the community focused on populations experiencing homelessness. SOR funding has provided support for two peer-led programs, mobile recovery teams, peer recovery support services, and peer-led warm lines. Within these services, individuals are helped with housing, employment, transportation, legal issues, and other supports that promote recovery and well-being. While impressive, these programs are limited in scope and availability. The State also appears to lack statewide community-based recovery supports such as recovery centers. Documents reviewed did not mention recovery supports targeted at children, adolescents, or transition-age youth.

---

[247] Substance Abuse and Mental Health Services Administration. *Recovery-Oriented Systems of Care Resource Guide,* 2010. Available at: https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

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

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

Nevada's June 2019 Statewide assessment using SAMHSA's CAST reviewed the capacity of recovery supports and identified needs, which varied by region, in the following categories:[250]

- Religious or spiritual advisors
- 12-step groups
- Transportation
- Employment support
- Educational support for those who have completed treatment
- Parenting education
- Assistance obtaining housing
- Assistance obtaining health insurance

A lack of capacity was identified for religious or spiritual advisors in all regions of the state, and the categories of employment support 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 behavioral health regions of the state.[251] Twelve-step groups, transportation for those receiving treatment, and parenting education for individuals with an SUD were identified as having adequate capacity at the state level, with a few regions noting gaps in those categories. Overall, the CAST prioritized housing and transportation as the most significant, foundational needs, considering that other recovery supports were being addressed by other entities. A small qualitative study of current and former opioid users indicated that the various treatment and support programs are fragmented and inadequate for the complexities of SUD. [252] 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.

The qualitative study of Nevadans with lived experience noted that peer supports are essential, not only in gaining trust for those in treatment, but also in offering recovery employment or volunteer opportunities. [253] They additionally noted that upon discharge from treatment, they were not educated on resources that would help maintain recovery.

Peer Support

Peer and Recovery Support Specialists (PRSS) have increasingly been shown to be an effective component of a substance use treatment continuum and should be woven

[250] State of 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.

[251] See Note 248 above.

[252] 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.

[253] 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.

throughout prevention, treatment, and recovery. In Nevada, peer supports have also been highlighted as a priority area for supporting pregnant and postpartum women and as a vital component of a successful crisis care response system, and prioritized by those with lived experience as an area of recommended growth:

- The Perinatal Health Action Plan, Goal 1, Primary Priority 1: Development of Services, includes advocacy for the development of programs that build in peer support, removal, or modification of prior authorization requirements for peer recovery support services to increase access to care, promotion of 24/7 peer-led warm lines, and continued State support of scholarships for peer recovery and support specialists working towards certification.[254] These issues are also noted more generally in the 2020 "Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report"[255] and flagged for expansion in the related 2021 plan to expand capacity, "Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity."[256]
- The 2020 report, "Nevada's Crisis Care Response System: Assets and Gaps,"[257] highlights peers as an element of a successful crisis response system through employment in Mobile Crisis Teams and Crisis Stabilization Facilities. Peer involvement in mobile crisis response was noted as a gap in Northern Behavioral Health Region counties, whereas Washoe County was highlighted as having peer support integrated in all but one crisis stabilization facility, although peers are not yet integrated into mobile response teams. The Southern Region was also flagged as lacking in mobile crisis response overall, as well as lacking in peer resources. For call center hubs, the need for peer staffing was highlighted as a priority by the Northern and Rural regions. Overall, the significant role of peers was noted as one of the top three gaps in essential principles and practices in all regions of the state.
- Themes identified through the 2022 report "Voices of the Opioid Epidemic, Perspectives of Those with Lived Experience in Nevada"[258] include the recommendation for peer support for individuals who use/used and for families of those who use/used, as well as increasing availability of support groups to help both individuals who use/used and for families of those who use/used.

The second round of SOR funding expanded peer support services, resulting in 608 new clients receiving peer support assistance.[259] 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 the end of the first month of services, day shifts were added. In August 2021, the team expanded operations in the hospital to provide 24/7 support. The team received 177 referrals or handoffs from the

[254] State of Nevada Department of Health and Human Services. *Perinatal Health Initiative & SUPPORT Act*, 2020.

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

[256] State of Nevada Division of Health Care Financing and Policy. *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity,* 2021.

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

[258] 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

[259] 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.

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 in November of 2021. Additionally, a peer warm line in Southern Nevada helps connect individuals to care, support, and information.[260]

Gaps in Recovery Support[260]

- Access to desired peer supports for pregnant and postpartum women
- Statewide availability of peer supports throughout the treatment and recovery system

Social Determinants of Health

SDOH are "…conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."[261] SDOH factors include financial resources, social and community factors, education access and quality, health care access and quality, and the neighborhood and environment in which a person lives, including transportation, crime, and environmental quality. SDOH play an important part in health outcomes, and outcomes related to substance use prevention and treatment are no exception.

The 2019 Nevada State Health Needs Assessment 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.[262] 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.[263]

The Nevada Minority Health Equity Coalition's qualitative study reiterated the importance of transportation, work, and stable housing in recovery.[264] 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

[260] Ibid...

[261] Centers for Disease Control and Prevention. "About Social Determinants of Health (SDOH)," accessed May 2022. Available at: https://www.cdc.gov/socialdeterminants/about.html

[262] State of 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.

[263] 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.

[264] 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 caseworkers and family members, both of which could have increased their access to treatment and additional recovery supports.

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

Nevada does have a 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.

Gaps in SDOH[265]

- Lower income and higher unemployment and poverty for those living on tribal lands
- Housing vouchers and housing assistance for at-risk populations (especially Northern and Southern regions and Clark and Washoe Counties)
- Transportation for both treatment and recovery support activities
- Employment for those receiving treatment
- Volunteer and vocational opportunities for those in recovery
- Internet access for people engaging in treatment
- Financial resources for people in treatment and recovery

[265] The designation of a gap does not mean the service or program does not exist, but that it is currently insufficient in scope, geographic coverage, resources for sustainability, or populations covered.

Section 6

Recommendations

The preceding needs assessment qualitative and quantitative findings from all seventeen counties representing Nevada's rural, frontier, and urban communities, as well as Native American tribes, informed the following list of recommendations. The recommendations were further developed using results from a survey of Nevada State agencies and through feedback and public input from the ACRN and SURG. The Johns Hopkins School of Public Health Principles for the Use of Funds from the Opioid Litigation document, as well as the nine core abatement strategies developed by Johns Hopkins, were used as additional guides for this assessment and planning process. Recommendations resultant from Nevada's prior work with the Johns Hopkins framework can be found in Appendix C.

Nevada has chosen to align efforts to expend bankruptcy or settlement recoveries with the five Principles for the Use of Funds from the Opioid Litigation developed by Johns Hopkins School of Public Health:[266]

- Spend money to save lives.
- Use evidence to guide spending.
- Invest in youth prevention.
- Focus on racial equality.
- Develop a fair and transparent process for deciding where to spend the funding.

The following nine core abatement strategies developed by Johns Hopkins were also critical in development of the recommendations and the subsequent Statewide Plan for the use of funds:[267]

- Broaden access to naloxone
- Increase use of medications to treat opioid use disorder
- Provide treatment and supports during pregnancy and the postpartum period
- Expand services for neonatal opioid withdrawal syndrome
- Fund warm handoff programs and recovery services
- Improve treatment in jails and prisons

[266] Johns Hopkins Bloomberg School of Public Health. *Principles for the Use of Funds from the Opioid Litigation,* 2021. Available at: https://opioidprinciples.jhsph.edu/wp-content/uploads/2021/01/Litigation-Principles.pdf

[267] Johns Hopkins Bloomberg School of Public Health. *Primer on Spending Funds from the Opioid Litigation: A Guide for State and Local Decision Makers,* 2021.

- Enrich prevention strategies
- Expand harm reduction programs
- Support data collection and research

To further ensure that the decision-making process for funding projects was fair and transparent, Mercer was contracted to develop a rating system to indicate the urgency, feasibility, and potential impact the following recommendations could have on the intended populations. The “Total Score" listed at the end of each recommendation reflects the overall priority based on urgency, feasibility, and impact. Mercer also included an indicator as to whether each recommendation was responsive to NRS 433.736(1)(e) and the three legislative-designated priorities that are of overdose prevention, disparities in health care, and prevention of substance use among youth, as well as those suggested in the Johns Hopkins principles, overdose prevention, youth prevention, and health equity. Details of the rating methodology are presented in the Methodology Section. Nevada used the ratings as a tool to prioritize the recommendations according to the ratings to identify top potential priorities for funding.

The recommendations are divided into the following sections: Data, Prevention, Treatment, and Social Determinants of Health and Recovery Supports. Within each section, recommendations are categorized according to the NRS 433.738 list of allowable projects: Data, Reduce Harm, Prevention/Treatment/Recovery, Education/Awareness Campaign, Workforce Development, Prevent ACEs, Justice Programs, Reduce Neonatal Abstinence Syndrome, Crisis Services, Evaluate Programs, and Housing. Many recommendations might apply to multiple categories, but only one was chosen for each.

Data Recommendations

Data Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Establish Nevada all-payer claims database (APCD). The State is currently making progress on this recommendation. The database is intended to and should include claims for all medical, dental, and pharmacy benefits. The advisory committee that will make recommendations on the analysis and reporting of the data should ensure that key data elements are maintained through the de-identification process to ensure the data remain meaningful. Critical needs include the ability to stratify by special population characteristics (race/ethnicity, geography, LGBTQ+ status, pregnancy, etc.), and enough detail to identify physical and behavioral health comorbidities.	Data	4.0	4.0	3.7	3.0	**14.7**
Develop an overdose fatality review committee(s).	Data	3.3	3.5	3.7	3.0	**13.5**
Support the Automated Program Interface (API) connection to EMS/Image Trend for data collection and reporting through the overdose mapping and application program (ODMAP).	Data	3.0	3.5	4.0	3.0	**13.5**
Support Poison Control hotline and data collection/reporting to track and trend; establish a communications system and dashboard.	Data	3.0	3.5	4.0	3.0	**13.5**
Expand reporting to the prescription drug-monitoring program to include methadone to increase patient safety and reduce prescribing risk.	Data	2.3	2.5	4.7	3.0	**12.5**
Share standardized data between public safety agencies and those monitoring local overdose spike response plans. This will support local partners so they may act quickly when needed.	Data	3.0	3.0	3.0	3.0	**12.0**
Evaluate the outcomes from the Association of State and Territorial Health Officials Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative and State Opioid Response grant projects for pregnant and postpartum women and their infants, and implement lessons learned. Ensure that outcome data is detailed and stratified by important demographic characteristics in order to detect and address health disparities. Review of the outcomes from these projects will allow Nevada to analyze lessons learned and apply successes for future initiatives addressing SUD in additional identified special populations.	Data	2.7	2.0	3.7	3.0	**11.3**
Establish a minimum data set for suspected opioid use and overdose death data collection to standardize data across the state and better	Data	3.3	2.0	3.3	3.0	**11.7**

Data Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
prevent overdoses. The NV-OD2A program has identified a minimum data set from law enforcement and other first responder agencies. The minimum data set relates to indicators that law enforcement agencies can collect and report on, although at the time the report was written, none were using the full minimum data points.						
Improve and standardize forensic toxicology testing and data. There are additional ways the State could get toxicology information to inform public health and public safety agencies about what is in the drug supply and what the potential risk for an overdose may be. These methods include testing of seized drugs through a lab or by field test, testing of syringes, wastewater testing, and urinalysis of people who have experienced a nonfatal overdose.	Data	2.7	1.5	2.7	3.0	**9.8**
Develop data tools to collect and report racial, ethnic, housing status, sexual orientation, and gender identity across datasets.	Data	2.0	3.5	4.0	0.0	**9.5**
Develop a statewide forensic toxicology lab that can support surveillance sample testing and other types of toxicology testing that may increase the amount of information used to inform community awareness of overdose risk, including substances involved in suicides.	Data	3.0	1.5	1.7	3.0	**9.2**
Increase data sharing using the HIE. Promote the use of HealtHIE Nevada chart provider portal at no cost to providers. Funding should be provided to providers in need of system updates or changes to allow for participation. This will increase the ability to share data across behavioral and physical health providers.	Data	3.0	2.5	3.3	0.0	**8.8**
Develop and maintain consistent query code and query logic for reporting on standard metrics across agencies to facilitate consistent reporting and monitoring of priority indicators related to the opioid epidemic. Develop and maintain a consistent timeline for when metrics should be run and reported. Develop a standard process for quality control and consistencies, as well as reporting caveats.	Data	2.7	2.0	3.7	0.0	**8.3**
Increase reporting of Treatment Episode Data Set (TEDS) for all certified providers.	Data	2.7	2.5	3.0	0.0	**8.2**
Increase availability and access to real-time substance use disorder (SUD) and opioid use disorder (OUD) reports. The State of Nevada has multiple sources that could provide real-time data. The health information exchange (HIE), electronic health record (EHR) systems, birth registries, the Prescription Drug Monitoring Program (PDMP), and	Data	2.7	2.5	2.7	0.0	**7.8**

Data Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
OpenBeds should be evaluated for interoperability-based use cases that will provide the needed data for analysis. Non-claims-based data sources should also be utilized to ensure the capture of all necessary data.						
Partner with local coroner/medical examiner, medical schools, and other relevant stakeholders to develop an accredited forensic pathology program.	Data	2.7	2.0	2.3	0.0	**7.0**
Expand surveillance testing. This will require a new funding formula for forensic toxicology, as well as better leveraging of federal funds.	Data	2.7	1.5	2.7	0.0	**6.8**

Prevention Recommendations

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Establish a "bad batch" communications program to alert communities to prevent mass casualty events.	Reduce Harm	4.0	4.5	4.0	3.0	**15.5**
Establish a disease investigation model for non-fatal overdoses to identify and mitigate risk.	Prevention/Treatment/ Recovery	3.3	4.5	4.0	3.0	**14.8**
Utilize an education and awareness campaign focused on identification of the need for treatment and treatment options, targeted to people using opioids and their families. The campaign should be tailored for different populations in order to promote health equity. Populations targeted should include those without housing.	Education/Awareness Campaign	3.3	4.5	3.3	3.0	**14.2**
Increase education to decrease stigma and enhance understanding of recovery for employers and landlords through the Recovery Friendly Workplace Initiative.	Education/Awareness Campaign	3.3	4.5	3.3	3.0	**14.2**
Implement Mobile Crisis Teams with harm reduction training and naloxone leave-behind.	Reduce Harm	3.3	3.5	4.3	3.0	**14.2**
Increase education on the safe use and storage of opioids. Statewide campaign should be developed to provide consistent education and standardized guidance on the use and storage of opioids, such as the Office of Suicide Prevention's Safe Storage Efforts. This campaign should also include resources for safe disposal of opioids, which should include engaging law enforcement, the State, and pharmacies to develop easily accessible safe disposal resources.	Education/Awareness Campaign	3.7	3.5	4.0	3.0	**14.2**
Develop no-barrier access to overdose prevention/harm reduction services, including naloxone and fentanyl testing.	Reduce Harm	3.0	4.0	4.0	3.0	**14.0**
Purchase and distribute hand-held drug testing equipment (mass spectrometers) to allow for rapid testing of substances.	Reduce Harm	3.3	5.0	2.7	3.0	**14.0**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Implement an education campaign on the addictive potential of opioids and alternative therapies for chronic pain and chronic illness, especially in rural areas, that is tailored to geography and underserved populations.	Education/Awareness Campaign	3.7	3.5	3.7	3.0	**13.8**
Maintain distribution of naloxone kits. Although naloxone is available and public education on the benefits and use have increased, the funding for current efforts is primarily driven by grants and subsidies and a long-term sustainability plan is needed to ensure continued access is available. It is also essential to ensure that further educational efforts are targeted at special populations and groups experiencing disproportionate overdoses.	Reduce Harm	3.7	3.5	3.7	3.0	**13.8**
Implement universal screening for ACEs and SBIRT in pediatric care settings. Reimburse in Medicaid under early and periodic screening, diagnosis, and treatment (EPSDT) provision.	Prevention/Treatment/ Recovery	3.3	4.0	3.3	3.0	**13.7**
Fund the integrated care training program. Training in the integration of physical and behavioral health can not only help to identify substance use and potential misuse earlier, but it can address other problems, such as mental health issues, before they contribute to substance use. Training should consider the unique landscape of rural, frontier, and tribal communities. Training should also include a focus on Social Determinants of Health (SDOH) and can be tailored for opioid issues in special populations, such as adolescents and transition-age youth, or pregnant and postpartum women, and underserved individuals such as people of color.	Develop Workforce	4.0	3.0	3.7	3.0	**13.7**
Develop and implement parent education opportunities, resources, and supports for SUD prevention.	Prevention/Treatment/ Recovery	3.0	4.0	3.7	3.0	**13.7**
Implement public messaging campaign on the prevention and impact of ACEs.	Prevent ACEs	3.0	4.0	3.7	3.0	**13.7**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Provide parent education on ACEs prevention and intervention.	Prevent ACEs	3.0	4.0	3.3	3.0	**13.3**
Implement initiatives prior to release from prison that provide information on and connection to post-release treatment and housing, as well as education on the risks of overdose after periods of abstinence.	Justice Programs	3.0	4.0	3.3	3.0	**13.3**
Provide support for commercially sexually exploited children through receiving centers and ongoing treatment.	Prevention/Treatment/ Recovery	2.7	4.0	3.7	3.0	**13.3**
Prioritize naloxone and fentanyl test strip distribution to people who use drugs and to clinics that provide MAT services.	Reduce Harm	3.0	3.0	4.3	3.0	**13.3**
Train providers and pharmacists on how to educate patients about pain management expectations and the risk of opioids. Provide tools and patient education materials for statewide use as well as materials tailored for underserved populations. Collaborative care agreements should fully utilize pharmacists as part of the care team.	Develop Workforce	3.3	3.5	3.3	3.0	**13.2**
Expand access to harm reduction products through the purchase and distribution of vending machines statewide.	Reduce Harm	3.3	3.5	3.3	3.0	**13.2**
Promote youth substance misuse interventions.	Prevention/Treatment/ Recovery	3.0	3.5	3.7	3.0	**13.2**
Provide prevention specialists for schools to support implementation of evidence-based practices in grades K–12.	Prevention/Treatment/ Recovery	3.0	3.0	4.0	3.0	**13.0**
Implement Trauma-Informed Schools.	Prevention/Treatment/ Recovery	3.3	3.0	3.7	3.0	**13.0**
Prioritize naloxone distribution to people at highest risk for overdose death. This will require a more systematic data collection effort to drive allocation of resources towards the people and communities with high death rates, as well as innovative efforts to connect with people at highest risk (e.g., people who	Reduce Harm	3.0	3.0	4.0	3.0	**13.0**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
are housed, living alone, or living in settings in which drug use is hidden).						
Expand educational efforts in the schools to promote early intervention and reduce stigma. Curricula such as Mental Health First Aid can be an effective method of assisting youth in identifying the signs of suicidality in their peers in a way that reduces stigma and increases knowledge of how to promote intervention. Continued training on the signs and interventions of suicide and substance use in the school system for parents, law enforcement, and other community partners will assist in reducing stigma and assisting in identifying individuals at risk, allowing for potential earlier intervention and decreased risk for lethality.	Education/Awareness Campaign	3.3	3.5	3.0	3.0	**12.8**
Continue the use of comprehensive preventive services rooted in harm reduction principles. Harm reduction can be an effective way of decreasing risk in multiple areas, from overdose to reduction of HIV and other diseases. It allows for education and intervention with active users who may be in the early stages of change and assists with linkage to treatment. Efforts should include community members, organizations, volunteers, professionals, and other stakeholders to become engaged members of the harm reduction and prevention workforce. Planning, implementation, and monitoring should meaningfully involve people with lived experience.	Reduce Harm	3.0	3.5	3.3	3.0	**12.8**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Increase the number of providers trained to offer trauma-informed treatment. There is a connection between exposure to childhood trauma and risky behaviors such as substance abuse. Nevada should consider offering trauma-informed training to all provider types, from primary care physicians to OB/GYNs, as well as to school personnel. Mental Health First Aid could be used in the school setting, as well as in primary care settings, to educate individuals on the effects of childhood trauma and available resources. Education on recognizing the signs of trauma and appropriate treatment will allow for earlier intervention and prevention efforts.	Prevention/Treatment/ Recovery	3.7	3.5	2.7	3.0	**12.8**
Provide reports or analytics from the PDMP that allow the State to identify demographic characteristics of those prescribed controlled substances for prevention of future overdoses.	Data	3.0	2.5	4.3	3.0	**12.8**
Standardize clinical guidelines for non-pharmacological treatments, such as physical therapy, cognitive-behavioral therapy, and chiropractic care. A workgroup should be established with representation from the medical and pharmacy State boards, as well as Medicaid leadership and managed care organization (MCO) leadership. The workgroup could focus on education on non-pharmacological treatment and work to improve formulary coverage and reimbursements for non-pharmacological treatments and multidisciplinary pain management treatment models. This must include physical and behavioral health services.	Prevention/Treatment/ Recovery	3.0	3.0	3.7	3.0	**12.7**
Increase access to Afterschool, Summer Recreation, and Intermural Programs in grades K–12.	Prevention/Treatment/ Recovery	3.0	3.0	3.7	3.0	**12.7**
Implement a school screening tool to identify adverse childhood experiences and provide early intervention	Prevent ACEs	2.7	4.0	3.0	3.0	**12.7**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
for children and their families. Provide appropriate referrals for treatment/counseling services.						
Implement Multi-tiered Systems of Support (Tier 1 and 2) and Social-Emotional Learning in all K–12 Schools.	Prevention/Treatment/ Recovery	3.0	3.0	3.7	3.0	**12.7**
Implement Multi-tiered Systems of Support (Tier 3) in all K–12 schools.	Prevention/Treatment/ Recovery	3.0	3.0	3.7	3.0	**12.7**
Implement family-based prevention strategies, especially for transition-age youth and young adults.	Education/Awareness Campaign	3.3	3.5	2.7	3.0	**12.5**
Invest in Families First Prevention Act activities to reduce risk for child welfare involvement.	Prevent ACEs	2.7	3.5	3.3	3.0	**12.5**
Work in concert with the Nevada public and private school districts for the development of mandatory age-appropriate prevention education and educator training for K–12 grades (specific to the SAMHSA strategic prevention framework, good behavior model, evidence-based curriculum) to include use of naloxone and how to talk with healthcare providers when age-appropriate.	Prevention/Treatment/ Recovery	3.0	3.0	3.3	3.0	**12.3**
Implement child welfare best practices for supporting families impacted by substance use.	Prevent ACEs	2.7	3.0	3.3	3.0	**12.0**
Increase prescriber training in graduate school. Training would be more effective if mandated as a part of graduate school education. Medical school curriculum should include education around buprenorphine, naloxone, and methadone, in addition to training of safe opioid prescribing and pain management practices.	Develop Workforce	3.0	2.5	3.3	3.0	**11.8**
Support an increase in needle exchanges across the state. Many non-profit organizations provide needle exchange services, but more sites are needed in locations where those using them feel safe and anonymous. In addition, sites could expand services to include distribution of naloxone, and to provide education regarding recovery and treatment as well	Reduce Harm	3.0	3.0	2.7	3.0	**11.7**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
as public health services. In areas that are currently not receptive to initiating needle exchange programs, increased education needs to be provided to help the community recognize and accept the importance of these programs and the long-term impacts for not only the communities but also those with OUD.						
Develop special medical school programs. Work with medical schools to offer specialized residencies or free or subsidized tuition for students who enter into the behavioral health field and serve in rural and frontier communities or with underserved populations for a specified number of years.	Develop Workforce	3.7	2.5	2.3	3.0	**11.5**
Train statewide law enforcement personnel on the protections in the 911 Good Samaritan Law and the revised statute on paraphernalia possession so they are enforced as intended. Currently, the fear of law enforcement intervention may put people at risk for drug overdose, HIV infections, and other health harms.	Justice Programs	2.3	3.5	2.7	3.0	**11.5**
Align priorities of 911 Good Samaritan Law protections with the enforcement of drug-induced homicide (DIH) laws by de-prioritizing enforcement of the DIH law.	Justice Programs	2.3	3.5	2.7	3.0	**11.5**
Fully implement the Zero Suicide framework statewide, including leading system-wide culture change, training the workforce, identification, client engagement, treatment, transition to lower levels of care, and quality monitoring and improvement.	Prevention/Treatment/ Recovery	4.3	4.0	2.7	0.0	**11.0**
Promote neonatal abstinence syndrome prevention programs through home visits and parenting programs for pregnant and parenting persons with OUD.	Reduce Neonatal Abstinence Syndrome	3.0	3.5	3.7	0.0	**10.2**
Incentivize and implement SBIRT in OB/GYN settings.	Reduce Neonatal Abstinence Syndrome	2.7	3.5	3.7	0.0	**9.8**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Create an office/position that can increase education, adoption, and support for SBIRT in all health care settings (e.g., inpatient, outpatient, etc.) similar to Zero Suicide Initiative.	Prevention/Treatment/ Recovery	3.3	2.5	3.7	0.0	**9.5**
Provide analytics from the PDMP to providers to identify polysubstance use. The PDMP can be used to identify trends in stimulant prescriptions issued and dispensed. Replicating some of the work done with opioid reporting to address prescribing practices would assist in addressing issues of stimulant prescribing.	Prevention/Treatment/ Recovery	3.0	3.0	3.3	0.0	**9.3**
Conduct anonymous school survey targeted to principals and staff to identify specific drug trends/issues in their schools. Results could inform additional training/resources for their students and parents.	Prevention/Treatment/ Recovery	3.0	3.0	3.3	0.0	**9.3**
Implement Safe Baby Courts for families impacted by substance use.	Justice Programs	2.3	4.0	3.0	0.0	**9.3**
Create an Office of Strategic Initiatives, as recommended by the DHHS task force, to coordinate activities across DHHS for programs supporting families impacted by parental substance use.	Prevention/Treatment/ Recovery	2.7	3.0	3.7	0.0	**9.3**
Offer MAT providers training and incentives for participation in the patient-centered opioid addiction treatment (PCOAT) model. Incentivize treatment recruitment and retention for individuals with OUD through the PCOAT Model in Medicaid. Implement procedures and policies necessary to operate the model.	Prevention/Treatment/ Recovery	2.7	2.5	4.0	0.0	**9.2**
Partner with surrounding states to share PDMP data. State leadership should work with neighboring states to establish a way to share PDMP data across state lines. Nevada has PDMP partnerships with 34 states and shares data with four of the bordering five states' PDMPs. California does not share data with Nevada,	Data	3.0	3.0	3.0	0.0	**9.0**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
creating a significant barrier for monitoring and harm reduction efforts along the Nevada-California border.						
Promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) for primary care. Utilizing SBIRT screenings in primary care visits for all populations, including adolescents, pregnant women, and other populations, will allow for increased early identification of potential substance use problems and allow for a more preventative, early intervention model of treatment. Nevada may also wish to increase awareness of the availability of SBIRT training, and coordinate with the MCOs, as well as other health care providers, to increase training opportunities.	Prevention/Treatment/ Recovery	3.0	3.0	3.0	0.0	**9.0**
Promote careers in behavioral health through early education. Workforce development can begin as early as high school to engage students, especially in rural and frontier communities, to pursue a career in behavioral health. Possible resources could include ambassador programs, virtual mentoring, student training, scholarships, and mentorship.	Develop Workforce	3.3	2.5	3.0	0.0	**8.8**
Address stigma among providers of all types. Enhanced educational and training practices with strategies to influence provider attitudes and reduce stigma can increase provider willingness to offer SUD treatment and recovery services. Anti-stigma training can also benefit primary care, dental, and emergency department providers by promoting more compassion when interacting with people with SUD and in recovery.	Prevention/Treatment/ Recovery	3.0	3.0	2.7	0.0	**8.7**
Establish supervised drug consumption sites.	Reduce Harm	2.7	4.0	2.0	0.0	**8.7**

Prevention Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Implement marketing and communications campaigns to combat stigma in the general public. Campaigns should be tailored to address stigma toward different groups, such as pregnant women, criminal justice-involved people, and youth, and can be delivered in a variety of ways, from online/social media videos to curricula in school health classes, to target different audiences. People with lived experience and those in the target audience can be of assistance in tailoring material to have a meaningful impact. In addition, utilizing success stories from individuals in recovery can be a powerful part of a marketing campaign.	Education/Awareness Campaign	2.7	2.5	3.3	0.0	**8.5**
Establish an advisory board that informs implementation of harm reduction services that includes people in recovery, people with lived experience of substance use, and people currently using drugs. The board can provide oversight and inform the equitable and ethical integration of harm reduction into routine public health services.	Reduce Harm	2.7	2.5	3.3	0.0	**8.5**
Establish home visiting programs for families at risk for or impacted by OUD.	Prevention/Treatment/ Recovery	2.3	3.0	3.0	0.0	**8.3**
Evaluate key partnerships. Nevada can work with CASAT and targeted organizations to identify physician-champions with addiction treatment experience to serve as consultants or mentors to peers.	Develop Workforce	2.7	2.0	3.7	0.0	**8.3**

Treatment Recommendations

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Engage non-traditional community resources to expand treatment access in rural or underserved areas and target populations that experience health disparities. Encourage non-traditional community resources, such as churches or community centers, to serve as spokes in the Medication Assisted Treatment (MAT) hub-and-spoke model. The State should also consider population-specific programs and resources to target the provision of services through existing efforts like women's health programs.	Prevention/Treatment/ Recovery	3.7	3.5	3.7	3.0	**13.8**
Incentivize providers for OBOT through bonuses. Targeted incentives may be used in rural areas to assist in increasing the workforce base. Other incentives may include bonuses to providers who meet pre-defined threshold(s) for providing SUD and OUD treatment and recovery services for those who participate in Project ECHO.	Develop Workforce	3.3	3.5	3.7	3.0	**13.5**
Implement plan for expansion of mobile MAT treatment for rural and frontier communities. Nevada has been exploring purchasing vans to enable mobile MAT treatment for more rural areas, which will assist in providing treatment in areas where it may not be financially feasible for a provider to open a brick-and-mortar facility. Implementation of the plan for mobile services will assist in increased access in these underserved communities.	Prevention/Treatment/ Recovery	3.3	4.0	3.0	3.0	**13.3**
Expand adolescent treatment options across all American Society of Addition Medicine levels of care for OUD with co-occurring disorder integration.	Prevention/Treatment/ Recovery	2.7	4.0	3.7	3.0	**13.3**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Improve upon evidence-based SUD and OUD treatment and recovery support training and resources for providers. Enhance trainings to include culturally tailored and linguistically appropriate services in an effort to decrease health disparities and evaluate current services to determine any possible expansions. Trainings may also include tools to determine the level of risk for relapse.	Develop Workforce	3.0	3.0	4.0	3.0	**13.0**
Increase evidence-based suicide interventions to help decrease intentional overdoses.	Prevention/Treatment/ Recovery	3.0	4.0	3.0	3.0	**13.0**
Work with parole and probation officers to educate them on the need for treatment and recovery, and assist individuals returning to the community to have increased support in achieving and maintaining sobriety in the community, as supported in AB 236. Treatment planning for these individuals should also include housing and employment interventions to ensure resources are in place to support the individual in the community.	Justice Programs	3.0	3.5	3.3	3.0	**12.8**
Directly fund people either at tribes or through the Nevada Indian Commission. To the extent that a tribe, the Inter-Tribal Council of Nevada, Nevada Urban Indians, or the Las Vegas Indian Center want direct funding, provide them with direct funding.	Prevention/Treatment/ Recovery	3.0	2.5	4.3	3.0	**12.8**
Continue efforts to work with tribal communities to meet their needs for prevention, harm reduction, and treatment. Continue to build relationships with the tribal populations by collaborating with their representatives and pursuing outreach to tribal communities through channels such as survey and focus groups.	Prevention/Treatment/ Recovery	3.3	3.0	3.3	3.0	**12.7**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Accurately identify capacity of SUD and OUD treatment providers. Since many providers such as Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatments (OBOTs) are not delivering services to capacity, a review of available data sources such as Medicaid claims and information from the Office of Analytics, Primary Care Association and other entities can be used to determine the current provider network array and determine where there are gaps, especially in the fee-for-service system. Developing a provider gap and needs assessment will allow the State to target specific areas and provider types as part of the effort to provide as full a continuum of care as possible. Managed care contracts should include provider adequacy requirements for MAT. Information should include the patient capacity of providers. The gaps analysis should include culturally relevant indicators, such as the availability of tribal providers and distance of underserved populations from existing providers.	Develop Workforce	3.3	3.0	3.3	3.0	**12.7**
Expand the Integrated Opioid Treatment and Recovery Centers (IOTRC) hub classification beyond Certified Community Behavioral Health Clinic (CCBHC), FQHC, and OTP. This will allow a broader category for hub designation to better accommodate underserved communities. Additionally, encourage the inclusion of non-traditional community resources to serve as spokes, and consider population-specific programs and resources to target the provision of services through existing efforts like women's health programs.	Prevention/Treatment/ Recovery	3.3	3.0	3.3	3.0	**12.7**
Expand MAT into adult correctional and juvenile justice facilities. Expand current pilot efforts to provide MAT services within correctional facilities prior to release to help remove lapses in treatment. This would require collaboration and engagement effort with counterparts in the state and local criminal justice systems.	Justice Programs	3.0	4.0	2.7	3.0	**12.7**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Partner with a TeleMAT service provider. TeleMAT programs have been increasingly utilized during the public health emergency and have been shown to be as effective as in-person programs and have yielded increased retention rates among patients. Some payers, including Anthem, have partnered with TeleMAT service providers to expand access to MAT in rural populations. A TeleMAT program in conjunction with the extension of COVID-19 flexibilities could greatly expand access to and participation in MAT statewide.	Prevention/Treatment/ Recovery	3.0	2.5	4.0	3.0	**12.5**
Develop and implement a statewide plan for prevention, screening, and treatment for Adverse Childhood Experiences (ACEs) across state agencies and provider settings. Train providers and organizations on EBP's for mitigating harm from exposure to ACE's/resiliency training	Prevent ACEs	3.3	3.0	3.0	3.0	**12.3**
Ensure funding for the array of OUD services for uninsured and underinsured Nevadans.	Prevention/Treatment/ Recovery	3.0	3.5	2.7	3.0	**12.2**
Create street outreach teams to provide street medicine programs, harm reduction, psychiatry, and care management.	Prevention/Treatment/ Recovery	2.7	3.5	3.0	3.0	**12.2**
Address transportation needs as a SDOH. Nevada's new, Medicaid-funded non-emergency Secure Behavioral Health Transport service is equipped and staffed by an accredited individual to transport individuals in mental health crisis, including those on a legal hold. Resources may be needed to help providers with start-up costs as well as to fund transportation for people not covered by Medicaid. Additional transportation solutions need to be considered for the non-Medicaid population, especially in rural areas.	Prevention/Treatment/ Recovery	3.0	3.0	3.0	3.0	**12.0**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Increase provider training and education on the effective use of telehealth. The State currently supports telehealth utilization and billing. Providers may require training as increased flexibility due to COVID-19 has led to an increase in the use of telehealth and a need for training on how to use this modality to deliver treatment. Utilization of federal resources such as the American Medical Association's provider playbook can assist in these efforts. In addition, use of telehealth can assist in expanding services to rural and frontier areas, provide greater access to specialists such as eating disorder specialists, and assist individuals in finding providers with similar cultural backgrounds.	Develop Workforce	3.0	2.0	4.0	3.0	**12.0**
Increase the availability of evidence-based treatment for co-occurring disorders for adults and children through promotion of training, enhanced reimbursement for use of specific evidence-based models, and State-sponsored training. Ensure training opportunities are marketed and available to providers in rural and frontier areas.	Prevention/Treatment/ Recovery	3.0	3.0	3.0	3.0	**12.0**
Implement ages zero to three years programming to support families impacted by substance use.	Prevent ACEs	3.0	3.0	3.0	3.0	**12.0**
Expand access to long-acting buprenorphine medications.	Prevention/Treatment/ Recovery	2.7	2.5	3.7	3.0	**11.8**
Expand current 211 website to include successful recovery stories and outcome data that has been de-identified to assist in reducing the stigma amongst both providers and the general public toward people with SUD. The website could also link to available MAT providers, including OB-GYNs, as well as resources for SDOH and other factors in recovery. A section for families to inform them about supporting a family member in treatment and recovery would be helpful. Nevada may feature a family and consumer social marketing campaign on the website to include risks	Education/Awareness Campaign	3.3	2.0	3.3	3.0	**11.7**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
associate with use that is tailored to different populations experiencing health disparities.						
Establish a Medicaid benefit that supports the hub-and-spoke model. Use of the hub-and-spoke model will decrease travel time and the barrier of transportation for those in rural and frontier areas in accessing substance use services. Implementation of the model should also include establishing bundled payments, enhanced rates, or Medicaid health homes to sustainably fund the model and maintain existing gain, support building infrastructure for rural and frontier hubs, and specifically target providers who can be designated as hubs.	Prevention/Treatment/ Recovery	3.0	3.0	2.7	3.0	**11.7**
Ensure adequate funding of the State 988 crisis line such that mobile crisis can be connected by GPS and dispatched by the crisis line.	Crisis Services	3.3	4.5	3.7	0.0	**11.5**
Evaluate the outcomes from the Association of State and Territorial Health Officials Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative and State Opioid Response grant projects for pregnant and postpartum women and their infants and implement lessons learned. Ensure that outcome data is detailed and stratified by important demographic characteristics in order to detect and address health disparities. Review of the outcomes from these projects will allow Nevada to analyze lessons learned and apply successes for future initiatives addressing SUD in additional identified special populations.	Evaluate Programs	2.7	2.0	3.7	3.0	**11.3**
Expand Mobile Crisis and ensure that the service is of consistently high quality, leverages federal matching funds, and is available for individuals not covered under Medicaid. Mobile crisis is an important alternative in substance-related crisis situations where the service can offer effective interventions and follow-up that includes referral and connection to post-crisis treatment.	Crisis Services	3.3	4.0	3.3	0.0	**10.7**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Increase education, adoption, and support for buprenorphine as a first-line treatment for reproductive/birthing/pregnant, etc., patients with OUD.	Reduce Neonatal Abstinence Syndrome	2.7	4.0	4.0	0.0	**10.7**
Support crisis stabilization units across the state that can serve Nevada residents and offer critical diversion from EDs and jails for those with OUD.	Crisis Services	2.7	4.5	3.3	0.0	**10.5**
Evaluate outcomes from efforts to support SUD treatment for the criminal justice-involved population. Monitor outcomes of criminal justice-involved individuals. This may include individuals who are inducted into MAT prior to discharge, or other interventions, such as drug courts for individuals with polysubstance conditions, and working with probation and parole officers to support the needs of individuals in treatment and recovery to determine best practices for improvements in outcomes in this population.	Evaluate Programs	3.0	2.0	2.3	3.0	**10.3**
Expand use of referral mechanisms. Receive periodic updates from University of Nevada — Reno (UNR), State owner of OpenBeds. Update the referral process to include use of the eligibility checklist to enable referring providers to confirm Medicaid eligibility and initiate enrollment. Develop a user-friendly standardized form that providers can complete and send with referrals to improve coordination of care. Planning and implementation of this recommendation should ensure process is as streamlined as possible and results in decreased burden to providers. Provider stakeholdering may assist in ensuring further improvements.	Prevention/Treatment/ Recovery	2.7	3.5	4.0	0.0	**10.2**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Continue to support expansion of substance use services such as MAT in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), which could increase the availability of services in rural areas, as well as increase the coordination of behavioral and physical health for individuals in treatment. This effort would include an analysis of data and working with providers to determine how many individuals in their service area they may be able to accommodate. Key stakeholders and champions will be a necessary component for expansion of MAT, including change management in perception of MAT as addiction medicine being difficult and unappealing. Tracking outcomes to provide success stories of MAT services may also assist in this endeavor.	Prevention/Treatment/ Recovery	3.3	3.0	3.7	0.0	**10.0**
Incentivize providers to initiate buprenorphine in the emergency department (ED), as well as during inpatient hospital stays. All EDs and hospitals should have providers that will provide buprenorphine induction as well as involve case managers to assist with setting up outpatient resources for continued care and management.	Prevention/Treatment/ Recovery	2.7	4.0	3.3	0.0	**10.0**
Increase withdrawal management services in the context of comprehensive treatment programs.	Prevention/Treatment/ Recovery	3.0	4.0	3.0	0.0	**10.0**
Implement CARA Plans of Care with resource navigation and peer support.	Reduce Neonatal Abstinence Syndrome	3.0	3.0	4.0	0.0	**10.0**
Incorporate screening for standard SDOH needs as a routine intake procedure for all services.	Prevention/Treatment/ Recovery	3.7	3.5	2.7	0.0	**9.8**
Evaluate provider enrollment process to ensure the process of becoming a Medicaid provider is not deterring providers from enrollment. The State should evaluate current enrollment procedures, using available data including provider stakeholder group input to determine where there are opportunities to improve the	Develop Workforce	2.7	2.5	4.7	0.0	**9.8**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
provider enrollment process, encouraging more providers to join the Medicaid program.						
Expand treatment options for transitional age youth.	Prevention/Treatment/ Recovery	2.7	3.5	3.7	0.0	**9.8**
Expand access to medication-based OUD treatment options for youth with OUD in primary and behavioral health settings.	Prevention/Treatment/ Recovery	2.7	3.5	3.7	0.0	**9.8**
Increase longer-term rehabilitation program capacity.	Prevention/Treatment/ Recovery	2.7	4.0	3.0	0.0	**9.7**
Provide specialty care for adolescents in the child welfare and juvenile justice systems.	Justice Programs	3.0	4.0	2.7	0.0	**9.7**
Support the implementation of low threshold prescribing for buprenorphine treatment.	Prevention/Treatment/ Recovery	2.7	3.0	4.0	0.0	**9.7**
Establish IOTRCs in Department of Healthcare Financing and Policy/Nevada Medicaid policy with funding.	Prevention/Treatment/ Recovery	3.0	3.0	3.7	0.0	**9.7**
Use braided or blended funding, which merges multiple sources of funding for treatment that may not be fully covered by one individual funding source. Braided funding combines state, federal, and private funding streams for a united goal, ensuring individual funding sources are separately tracked and reported. Blended funding is the same principle, with the exception that all blended funding sources are combined and not tracked and reported on individually.	Prevention/Treatment/ Recovery	3.0	3.5	3.0	0.0	**9.5**
Fully implement Nevada's Hub-and-Spoke System for MAT regardless of payer.	Prevention/Treatment/ Recovery	3.0	2.5	4.0	0.0	**9.5**
Ensure the accuracy of the Nevada health professional shortage area designation process. Per the Health Resources and Services Administration (HRSA), states should routinely collect supplemental information (e.g., provider specialty, patient care hours). Improving the HRSA designations process will impact eligibility for organizations such as the Indian Health Service Loan Repayment Program, Centers for Medicare & Medicaid	Develop Workforce	3.3	2.0	4.0	0.0	**9.3**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Services (CMS) HRSA Bonus Payment Program, and Nursing Corp.						
Expand drug court treatment availability as well as treatment protocols to include treatment for multiple substances, including stimulants. Although some efforts have been made, such as the expansion of individuals able to be served by the Las Vegas-based 8th Judicial MAT Re-Entry Court to include those with a stimulant disorder, interventions for those who use multiple substances should be available statewide.	Justice Programs	2.3	4.0	3.0	0.0	**9.3**
Enforce parity across physical and mental health. For example, a pregnant patient who presents for delivery should receive all of the necessary substance use treatment and physical health care for the patient and newborn which would include labor and delivery, pediatrician, NICU, etc., as well in evaluation. Enforce the same for infectious disease specialists.	Prevention/Treatment/ Recovery	3.0	3.0	3.3	0.0	**9.3**
Train providers on evidence-based practices for family-focused SUD treatment interventions.	Develop Workforce	3.0	3.0	3.3	0.0	**9.3**
Promote Eat, Sleep, Console for mother/baby dyads for treating withdrawal.	Prevention/Treatment/ Recovery	2.3	3.0	4.0	0.0	**9.3**
Expand use of Project ECHO® and participate in Opioid ECHO to increase provider capacity. Nevada should seek to expand the current program, using data from Project ECHO regarding current MAT and pain management clinics to evaluate reach and effectiveness. Participant feedback can be used to address any areas of opportunity and current known barriers to becoming an OUD treatment services provider. Opioid ECHO, a main supporting hub at the ECHO Institute, provides expert specialist teams to state spoke sites. The model offers tools and resources to meet the need for prevention, screening, and treatment of OUD.	Develop Workforce	2.7	3.0	3.7	0.0	**9.3**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Expand access to childcare options for families seeking treatment/recovery supports.	Prevention/Treatment/ Recovery	2.7	3.5	3.0	0.0	9.2
Modify or remove prior authorization requirement for select outpatient behavioral health services. Several therapy services such as individual, group, and family therapy do not require prior authorization from in-network providers through Medicaid managed care. Nevada should consider removing these requirements from its fee-for-service system, which will decrease administrative burden for both providers and the State. Nevada currently requires prior authorization for Intensive Outpatient Programs (IOPs). While the State may not wish to remove prior authorization completely for this service, they may wish to consider modifying the prior authorization requirements. The benefit of requiring prior authorization after an initial time period supports the State in ensuring IOP level of care is appropriate for a beneficiary and encourages providers to revisit how and whether a patient should be advanced on the care continuum based on a real-time assessment.	Prevention/Treatment/ Recovery	3.0	2.5	3.7	0.0	9.2
Increase adolescent beds certified to treat young adolescent and transition-age youth, as well as capable of treating co-occurring disorders. Ensure facilities are accessible to populations most in need.	Prevention/Treatment/ Recovery	3.0	3.5	2.7	0.0	9.2
Engage OB/GYNs in an ECHO project to encourage and improve OUD screening, referral, and treatment for pregnant women.	Prevention/Treatment/ Recovery	2.7	3.5	3.0	0.0	9.2
Increase parent/baby/child treatment options, including recovery housing and residential treatment, that allow the family to remain together.	Prevention/Treatment/ Recovery	2.7	3.5	3.0	0.0	9.2

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Address housing needs as a SDOH. Nevada may utilize tenancy supports as an intervention to allow individuals to maintain housing as they go through the recovery process. In addition, development of sober housing resources and affordable housing through partners such as the Public Housing Authority can assist individuals in recovery in finding and maintaining affordable housing to enable ongoing recovery.	Housing	3.0	3.0	3.0	0.0	**9.0**
Increase provider rates for treatment in rural areas to incentivize providers to serve in rural communities. Work with licensure boards to ensure licensure and supervision rules do not pose barriers to practice and supervision in rural areas.	Develop Workforce	2.7	3.0	3.3	0.0	**9.0**
Establish Community Health Worker/Peer Navigator program for pregnant and parenting persons with OUD.	Prevention/Treatment/ Recovery	2.7	3.0	3.3	0.0	**9.0**
Provide grief counseling and support for those impacted by the fatal overdose by a family or friend.	Prevention/Treatment/ Recovery	2.3	3.0	3.7	0.0	**9.0**
Provide housing and recovery supports for homeless youth with OUD.	Prevention/Treatment/ Recovery	2.3	3.5	3.0	0.0	**8.8**
Capture data on workforce through the licensure renewal processes. Licensure renewal is another opportunity to capture workforce information from the State's 26 health-licensing boards. There are opportunities to efficiently collect standardized, longitudinal employment, demographic, and practice data on any health profession licensed by the State of Nevada. Such information can be used to capture existing and calculate projected clinical full-time equivalent (FTE) capacity needed to meet the demand for SUD. Combined with the data from the gap analysis, the information collected can help the State's strategic allocation of resources.	Develop Workforce	3.0	2.5	3.3	0.0	**8.8**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Provide continuity of care (CoC) between levels of care. Nevada's CCBHCs currently provide care coordination across various providers to ensure whole person treatment is available for both physical and behavioral health. These programs may need to be expanded to meet the needs of the state's OUD population for those not served by CCBHCs.	Prevention/Treatment/ Recovery	2.7	2.5	3.7	0.0	**8.8**
Require the use of evidence-based practices to address and treat polysubstance use in all treatment protocols and expand statewide access to interventions for those who use multiple substances (including through drug courts).	Prevention/Treatment/ Recovery	2.7	2.5	3.7	0.0	**8.8**
Increase availability of peer recovery support services. Peer supports are a valuable component of treatment, harm reduction, and recovery systems. Consider expanding internship programs, offering scholarships to pursue peer support certification, and promoting 24/7 peer-staffed call centers.	Develop Workforce	2.3	3.0	3.3	0.0	**8.7**
Develop employment supports for those in treatment and in recovery.	Prevention/Treatment/ Recovery	3.0	3.0	2.7	0.0	**8.7**
Increase access to evidence-based family therapy practices through training availability and increased funding/reimbursement.	Prevention/Treatment/ Recovery	3.0	3.0	2.7	0.0	**8.7**
Establish policies and funding to support evidence-based recovery housing using National Alliance for Recovery Residences criteria.	Prevention/Treatment/ Recovery	3.0	2.5	3.0	0.0	**8.5**
Align utilization management policies between Medicaid managed care and fee-for-service, such as preferred drug lists and under- and over-utilization reports for consistency in review of the overall system.	Prevention/Treatment/ Recovery	2.7	2.5	3.3	0.0	**8.5**
Establish addiction medicine fellowships.	Develop Workforce	3.0	3.0	2.3	0.0	**8.3**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Ensure all delivery hospitals and health care systems taking care of reproductive age, pregnant, and postpartum patients utilize currently available programming for pregnant patients that prioritizes best practices for patient, family/caregivers, and neonate/infant (i.e., SBIRT, outpatient care, inpatient care, delivery, reproductive planning, care coordination, Comprehensive Addiction and Recovery Act of 2016 [CARA] plan of care, treatment, NAS, etc.).	Reduce Neonatal Abstinence Syndrome	2.7	3.0	2.7	0.0	**8.3**
Expand 211 to identify and match individuals to resources for SDOH. As part of expanding resources, current partnerships should be reviewed to see if there is an opportunity for expansion or additional collaboration.	Prevention/Treatment/ Recovery	3.0	1.5	3.7	0.0	**8.2**
Implement a reimbursement model that reduces the administrative burden of administering grant funds for organizations not accustomed to handling grant payments. One way to do this would be to run the reimbursement payments through the edits built into the Medicaid Managed Information System (MMIS); when the reimbursement is not a Medicaid expense it would filter down to the Division of Public and Behavioral Health (DPBH) code and be paid from State or federal grant money.	Prevention/Treatment/ Recovery	2.7	2.5	3.0	0.0	**8.2**
Require all SUD treatment programs to measure standard patient outcomes and implement best practices. Monitor for adherence to best practices, standards of care, and outcomes.	Evaluate Programs	3.0	2.5	2.7	0.0	**8.2**
Identify opportunities for faith-based organizations to provide recovery supports in local communities. Local communities should develop coalitions to work together to ensure recovery supports are available, including the development of local recovery centers.	Prevention/Treatment/ Recovery	2.3	3.0	2.7	0.0	**8.0**

Treatment Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Nevada has submitted an 1115 Demonstration SUD Waiver that will allow for payment of SUD services in Institutions for Mental Disease. Utilize FRN funding for states share for 1115 SUD Waiver, room and board, and uncompensated care.	Prevention/Treatment/ Recovery	2.0	2.0	4.0	0.0	**8.0**
Increase short-term rehabilitation program capacity.	Prevention/Treatment/ Recovery	2.3	3.0	2.7	0.0	**8.0**
Create non-commercially sponsored meeting forum for treatment and other resource providers to share practices, concerns, scholarship, and other topical information.	Prevention/Treatment/ Recovery	3.0	2.0	3.0	0.0	**8.0**
Create a scholarship fund dedicated to individuals directly affected by the epidemic.	Develop Workforce	2.0	2.5	3.3	0.0	**7.8**
Implement a workforce of community health workers throughout recovery supports, behavioral health, and social service agencies. This will potentially require planning, a new Medicaid service definition and associated budget expansion, and funds for the uninsured and underinsured to access these services.	Prevention/Treatment/ Recovery	2.7	2.5	2.0	0.0	**7.2**

SDOH and Recovery Support Recommendations

SDOH and Recovery Support Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Work with parole and probation officers to educate them on the need for treatment and recovery and assist individuals returning to the community to have increased support in achieving and maintaining sobriety in the community, as supported in AB 236. Treatment planning for these individuals should also include housing and employment interventions to ensure resources are in place to support the individual in the community.	Justice Programs	3.0	3.5	3.3	3.0	**12.8**

SDOH and Recovery Support Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Address transportation needs as a SDOH. Nevada's new, Medicaid-funded non-emergency Secure Behavioral Health Transport service is equipped and staffed by an accredited individual to transport individuals in mental health crisis, including those on a legal hold. Resources may be needed to help providers with start-up costs as well as to fund transportation for people not covered by Medicaid. Additional transportation solutions need to be considered for the non-Medicaid population, especially in rural areas.	Prevention/Treatment/ Recovery	3.0	3.0	3.0	3.0	**12.0**
Expand current 211 website to include successful recovery stories and outcome data that has been de-identified to assist in reducing the stigma amongst both providers and the general public toward people with SUD. The website could also link to available MAT providers, including OB-GYNs, as well as resources for SDOH and other factors in recovery. A section for families to inform them about supporting a family member in treatment and recovery would be helpful. Nevada may feature a family and consumer social marketing campaign on the website to include risks associate with use that is tailored to different populations experiencing health disparities.	Education/Awareness Campaign	3.3	2.0	3.3	3.0	**11.7**
Incorporate screening for standard SDOH needs as a routine intake procedure for all services.	Prevention/Treatment/ Recovery	3.7	3.5	2.7	0.0	**9.8**
Expand access to childcare options for families seeking treatment/recovery supports.	Prevention/Treatment/ Recovery	2.7	3.5	3.0	0.0	**9.2**

SDOH and Recovery Support Recommendations	Category	Impact Score	Urgency Score	Feasibility Score	Leg. Target	Total Score
Address housing needs as a SDOH. Nevada may utilize tenancy supports as an intervention to allow individuals to maintain housing as they go through the recovery process. In addition, development of sober housing resources and affordable housing through partners such as the Public Housing Authority can assist individuals in recovery in finding and maintaining affordable housing to enable ongoing recovery.	Housing	3.0	3.0	3.0	0.0	**9.0**
Develop housing and recovery supports for homeless youth with OUD.	Housing	2.3	3.5	3.0	0.0	**8.8**
Develop employment supports for those in treatment and in recovery.	Prevention/Treatment/ Recovery	3.0	3.0	2.7	0.0	**8.7**
Establish policies and funding to support evidence-based recovery housing using National Alliance for Recovery Residences criteria.	Prevention/Treatment/ Recovery	3.0	2.5	3.0	0.0	**8.5**
Expand 211 to identify and match individuals to resources for SDOH. As part of expanding resources, current partnerships should be reviewed to see if there is an opportunity for expansion or additional collaboration.	Prevention/Treatment/Recovery	3.0	1.5	3.7	0.0	**8.2**
Identify opportunities for faith-based organizations to provide recovery supports in local communities. Local communities should develop coalitions to work together to ensure recovery supports are available, including the development of local recovery centers.	Prevention/Treatment/Recovery	2.3	3.0	2.7	0.0	**8.0**

Section 7
Statewide Opioid Plan

The Statewide Plan is derived from the recommendations in the Needs Assessment (Sections 3–6 of this report) as well as from public comment and feedback from government agencies, ACRN and SURG meetings. The goals align with the national efforts of the Office of National Drug Control Policy's (ONDCP) National Drug Control Strategy.[268] The first goal and associated strategies includes infrastructure and capacity development to ensure local and community partners have the capacity and resources to implement recommendations effectively and sustainably. Each of the activities in the Plan includes priority scores derived from the corresponding recommendations found in Section 6. In cases where an activity encompasses more than one specific recommendation from the Needs Assessment, the highest priority score was listed. The Plan will be continuously reviewed and revised a minimum of every four years, or more frequently as needed, and distributed through the SURG and ACRN. The DHHS will also provide annual publicly available reports of all funding allocations and program activities to the State legislature.

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

Technical assistance for local communities in the dissemination, implementation, and ongoing fidelity to proven models (or evidence-based practices) used in the Statewide Plan is essential to ensuring that the programs recommended are implemented in a way that is effective and maintains fidelity to the original funding initiative over the long-term. Technical assistance is needed to identify local capacity to implement programs, provide remediation to fill in gaps between current capabilities and implementation, and offer ongoing implementation support. Implementation science will inform technical assistance to ensure sustainability. Health provider training and continuing education are also essential to build the workforce to a capacity that can effectively implement best practices.

Strategy 1.1: Build State Infrastructure to Assist in Local Capacity-Building and Ongoing Monitoring

Objective 1.1.1: Build Capacity to Provide Training and Technical Assistance for Local Entities

Activities:

- Establish a Nevada opioid training and technical assistance hub to support local communities to build capacity, identify and implement best practices, and coordinate training and technical assistance opportunities from state and national subject matter experts (SME)

- Create a website to serve as a central repository for training and technical assistance materials

Objective 1.1.2: Facilitate Coordination of Funding and Efforts across the State

Activities:

- Evaluation and mapping of currently funded opioid and substance use disorder projects
- Establish positions for regional opioid training and technical assistance to facilitate information sharing on opioid-related activities between local, regional, and state entities
- Establish a quarterly meeting for coordinators

Strategy 1.2: Support Funding Recipients in Planning and Implementation of Evidence-Based and/or Evidence-Informed Activities

Objective 1.2.1: Support Local Planning Efforts

Activities:

- Entity needs assessment/gaps
- Plan for implementation using findings from implementation science
- Provide technical assistance around evidence-based practices (EBPs) and evidence-informed services and projects
- Offer technical assistance for developing baseline, outcome measures, and reporting
- Technical assistance for target population identification
- Convene statewide pharmacist round table event

Objective 1.2.2: Support Initial Implementation of EBPs and Best Practices

Activities:

- Train on EBPs and evidence-informed services and projects during implementation
- Provide ongoing training as needed
- Offer technical assistance while monitoring the implementation
- Establish initial reporting requirements and process for funded programs
- Develop quality assurance activities that can braid across organizations

Strategy 1.3: Monitor Implementation and Fidelity to Program Models and Requirements

Objective 1.3.1: Timely Monitoring of Program Progress and Outcomes

Activities:

- Gather process reporting and financial reports from local entities
- Gather baseline and outcome data
- Provide technical assistance on remediation and quality improvement

Objective 1.3.2: Ensure Entities are Performing with Fidelity to the Chosen Model of Services or Programs

Activities:

- Conduct quality assurance and fidelity reviews
- Provide technical assistance to remediate any negative findings
- Monitor corrective actions plans
- Provide technical assistance on EBP or national best practices

Goal 2: Prevent the Misuse of Opioids

Prevention must be implemented at all levels, from targeting the general public to preventing overdose among those using opioids. However, not all prevention strategies work for everyone, so activities implemented must include consideration of any differential impacts or accessibility limitations potentially experienced by population subgroups that could result in health disparities. Many interventions necessitate alternative strategies for subgroups due to cultural and environmental differences from the general population. Detailed data collection and monitoring on demographic characteristics, selection of appropriate interventions, and involvement of the potentially impacted community members in planning and implementation are essential for ensuring health equity across prevention efforts.

Strategy 2.1: Prevent Opioid Use from Progressing to Misuse and Overdose

Objective 2.1.1: Identify Risk Factors for Opioid Misuse and Overdose

Activities:

- Identify risk factors through implementation of a disease investigation model for non-fatal overdoses and fatality review committees *(Priority Score: 14.8)*
- Identify substances involved in overdoses quickly (e.g., distribute hand-held drug testing equipment; *Priority Score: 14.0*)

Objective 2.1.2: Educate the General Public on Opioid Prevention and Treatment

Activities:

- Educate the public on the identification of treatment needs and treatment access and resources *(Priority Score: 14.2)*
- Leverage 211 to decrease stigma *(Priority Score: 11.7)*
- Promote available resources

Objective 2.1.3: Equip Providers to Prevent Opioid Misuse and Overdose

Activities:

- Educate providers and pharmacists on alternative pain management and on educating patients on patient pain management expectations and safe opioid use *(Priority Score: 13.8)*
- Increase opioid prescribing training in graduate schools for providers *(Priority Score: 11.8)*
- Decrease stigma/offer anti-stigma training for providers, including pharmacists *(Priority Score: 8.7)*
- Establish physician champions for addiction treatment training *(Priority Score: 8.3)*
- Standardize clinical guidelines for non-pharmacological pain management *(Priority Score: 12.7)*

Objective 2.1.4: Promote Safe Pain Management for Patients with Chronic Pain or Opioid Prescriptions

Activities:

- Educate patients on safe use, storage, and disposal of opioids *(Priority Score: 14.2)*
- Inform patients on addictive potential of opioids and alternative therapies for chronic pain *(Priority Score: 13.8)*

Objective 2.1.5: Educate Youth and Families in the Community to Reduce the Risk of Adverse Childhood Experiences (ACEs), Child Welfare Involvement, Opioid Misuse, and Overdose

Activities:

- Educate parents and the public on ACEs prevention and intervention *(Priority Score: 13.7)*
- Implement family-based prevention strategies and expand activities under the Family First Prevention Act *(Priority Score: 13.2)*

- Offer ACEs screening and referral to treatment in schools and medical settings *(Priority Score: 12.7)*

Objective 2.1.6: Support Youth and Adolescents Who Have Experienced ACEs and are At-Risk

Activities:

- Implement child welfare best practices for impacted families *(Priority Score: 12.0)*
- Implement safe baby courts for families impacted by SUD *(Priority Score: 9.3)*
- Ensure family-related efforts are coordinated across agencies *(Priority Score: 12.5)*
- Provide home visit programs for families impacted by SUD *(Priority Score: 8.3)*

Objective 2.1.7: Prevent Opioid Misuse and Overdose in Schools

Activities:

- Embed prevention specialists in K-12 schools *(Priority Score: 13.0)*
- Implement trauma-informed schools *(Priority Score: 12.8)*
- Increase access to aftercare, summer, and intramural programs *(Priority Score: 12.7)*
- Increase prevention in schools *(Priority Score: 12.8)*
- Require prevention education and educator training *(Priority Score: 12.3)*
- Provide school survey results on drug trends/issues to school leaders *(Priority Score: 9.3)*
- Provide access to prevention activities for the transitional aged youth (TAY) to ensure all youth/adolescent populations are targeted (*Priority Score: 12.5)*

Strategy 2.2: Detect Potential Misuse Early and Intervene to Prevent Increased Severity

Objective 2.2.1: Monitor the Prescription of Opioids and Related Substances

Activities:

- Provide enhanced PDMP analytics (including demographics and additional prescribed substances) information to providers *(Priority Score: 12.8)*
- Ensure PDMP data is obtained from all bordering states *(Priority Score: 9.0)*

Objective 2.2.2: Implement Screening and Early Intervention for All Nevadans

Activities:

- Prevent, screen for, and treat those with Adverse Childhood Experiences (ACEs) *(Priority Score: 12.3)*
- Implement ages zero to three programming to support families impacted by substance use *(Priority Score: 12.0)*
- Increase Screening, Brief Intervention and Referral to Treatment (SBIRT) statewide and train providers in integrated care *(Priority Score: 13.7)*
- Educate providers on the signs of trauma and appropriate referral options *(Priority Score: 12.8)*

Strategy 2.3 Define immediate solutions to reduce the risks for overdose and prepare for responses

Objective 2.3.1 Implement a Cross-sector Task Force to address overdose

Activities:

- Determine necessary action to reduce the risk of overdose in Nevada's communities.
- Prepare responses for the State and local jurisdictions in the event an increase in overdoses occurs
- Provide technical assistance, guidance, and resources to rapidly implement best practices to reduce risk for overdoses, enhance capacity to respond to events, and recover should such overdose events occur.

Goal 3: Reduce Harm Related to Opioid Use

Harm reduction is an approach that emphasizes engaging directly with individuals who use drugs to prevent overdose and transmission of infectious disease. Harm reduction is also meant to improve the physical, mental, and social well-being of those served, reducing stigma and offering low-threshold options for accessing substance use treatment.

Strategy 3.1: Prevent Opioid Overdoses among Those Already Using Opioids and Other Substances

Objective 3.1.1: Increase the Availability of Naloxone and Fentanyl Testing Supplies across Nevada

Activities:

- Implement Mobile Crisis Teams with naloxone leave-behind *(Priority Score: 14.2)*
- Provide access to fentanyl testing *(Priority Score: 14.0)*

- Increase naloxone distribution, targeting populations in need using data, including those using drugs and MAT clinics *(Priority Score: 13.8)*

Objective 3.1.2: Prevent Suicide-Related Overdoses

Activity:

- Implement Zero Suicide prevention efforts *(Priority Score: 11.0)*
- Establish crisis stabilization units, expand mobile crisis teams statewide, and ensure 988 funding *(Priority Score: 10.5)*

Objective 3.1.3: Support Safe Harm Reduction Behaviors among People Using Opioids

Activities:

- Establish safe places for opioid use that include harm reduction resources *(Priority Score: 11.7)*
- Expand the availability of harm reduction products in vending machines *(Priority Score: 13.2)*

Objective 3.1.4: Implement Statewide Harm Reduction Philosophy

Activities:

- Include people in recovery and those with lived experience with opioid use in planning efforts, to include peer programming *(Priority Score: 12.8)*
- Educate on the addictive potential of opioids and alternative therapies for chronic pain *(Priority Score: 13.8)*
- Promote public support for harm reduction efforts *(Priority Score: 11.7)*

Strategy 3.2: Decrease the Spread of Injection-related Morbidity and Mortality

Objective 3.2.1: Support Safe Intravenous Use

Activities:

- Expand accessibility of needle exchanges across the state *(Priority Score: 11.7)*
- Use exchange sites for additional harm reduction efforts *(Priority Score: 11.7)*

Goal 4: Provide Behavioral Health Treatment

Behavioral Health generally refers to mental health, substance use, and or co-occurring disorders which can include life stressors, crises, and stress-related physical symptoms. Behavioral health care and behavioral health integration refers to the prevention, diagnosis and treatment of these conditions by promoting whole-person care, closing treatment gaps, enhancing greater access to long-term monitoring services, reducing risk of self-harm,

increasing positive health outcomes, improving patient satisfaction and promoting long-term cost effectiveness. Behavioral health treatment is integral to aiding communities in recovering from substance use disorders and preventing new SUD among those with mental health diagnoses.

Strategy 4.1: Increase the Availability of Evidence-Based Treatment

Objective 4.1.1: Increase Training and Implementation Support for EBPs:

Activities:

- Improve upon evidence-based SUD and OUD treatment and recovery support training and resources for providers, including for subpopulations (e.g., children and families, tribal members) who need tailored treatment *(Priority Score: 13.0)*
- Increase evidence-based suicide interventions and trauma-informed care *(Priority Score: 13.0)*
- Increase the availability of evidence-based treatment for co-occurring disorders (COD) and use of multiple substances for adults and children through training and reimbursement for use of specific evidence-based models *(Priority Score: 12.0)*
- Monitor outcomes from the Association of State and Territorial Health Officials (ASTHO) Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative and State Opioid Response grant, especially identifying health disparities *(Priority Score: 11.3)*
- Improve OUD screening, referral, and treatment for pregnant women through Project ECHO *(Priority Score: 9.3)*

Objective 4.1.2: Provide a Variety of Evidence-Based and Best Practices Accessible to Nevada's Frontier, Rural, and Urban Populations

Activities:

- Increase withdrawal management services in the context of comprehensive treatment programs *(Priority Score: 10.0)*
- Implement Comprehensive Addiction and Recovery Act of 2016 (CARA) Plans of Care with resource navigation and peer support *(Priority Score: 10.0)*
- Use EBPs to support mothers, babies, and families impacted by opioid use *(Priority Score: 9.3)*
- Increase availability of peer recovery support services *(Priority Score: 8.7)*
- Ensure all providers prioritize best practices for patients, family/caregivers, and neonates/infants *(Priority Score: 8.3)*
- Require all SUD treatment programs to measure standard patient outcomes and implement best practices *(Priority Score: 8.2)*

- Implement community health workers throughout recovery supports, behavioral health, and social service agencies *(Priority Score: 9.0)*
- Provide grief counseling and support for those impacted by the fatal overdose by a family or friend *(Priority Score: 9.0)*
- Engage nontraditional community resources to expand treatment access in rural or underserved areas and target populations that experience health disparities *(Priority Score: 13.8)*
- Expand IOTRC hub classification beyond CCBHC, FQHC, and OTP *(Priority Score: 12.7)*
- Continue to work with tribal communities to meet their needs for prevention, harm reduction, and treatment *(Priority Score: 12.8)*
- Support referral to evidence-based practices *(Priority Score: 10.2)*
- Continue to expand MOUD in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) *(Priority Score: 10.0)*
- Increase longer-term and short-term rehabilitation program capacity *(Priority Score: 9.7)*
- Provide continuity of care between levels of care *(Priority Score: 8.8)*

Objective 4.1.3: Expand Treatment Options for Special Populations, Including Adolescents and Individuals with Co-Occurring Disorders

Activities:

- Expand adolescent treatment options across all ASAM levels of care for OUD with co-occurring disorder integration *(Priority Score: 13.3)*
- Expand treatment options for transition-age youth *(Priority Score: 9.8)*
- Provide specialty care for adolescents in the child welfare and juvenile justice systems *(Priority Score: 9.7)*
- Increase adolescent beds certified to treat young adolescent and transition-age youth, as well as capable of treating co-occurring disorders *(Priority Score: 9.2)*
- Establish Community Health Worker/Peer Navigator program for pregnant and parenting persons with OUD *(Priority Score: 9.0)*
- Increase parent/baby/child treatment options including recovery housing and residential treatment that allow the family to remain together *(Priority Score: 9.2)*

Objective 4.1.4: Expand/Maximize Capacity of Current Services and Increase Workforce

Activities:

- Promote healthcare profession career tracks in high school *(Priority Score: 8.8)*

- Encourage and support medical school students from rural or frontier communities *(Priority Score: 11.5)*
- Evaluate provider enrollment process to ensure it is not a deterrent for providers *(Priority Score: 9.8)*
- Incentivize providers to serve in rural and underserved communities *(Priority Score: 13.5)*
- Create a scholarship fund dedicated to individuals directly affected by the epidemic *(Priority Score: 7.8)*

Strategy 4.2: Increase Access to Evidence-Based Treatment

Objective 4.2.1: Expand Treatment Funding Options

Activities:

- Ensure funding for the array of OUD services for uninsured, underinsured, and tribal populations *(Priority Score: 12.2)*
- Offer sustainable funding for the IOTRCs *(Priority Score: 9.7)*
- Enforce parity across physical and mental health *(Priority Score: 9.3)*
- Modify or remove prior authorization requirement for selecting outpatient behavioral health services *(Priority Score: 9.2)*
- Align utilization management policies between Medicaid managed care and fee-for-service *(Priority Score: 8.5)*
- Implement a reimbursement model that reduces the administrative burden on providers of administering grant funds *(Priority Score: 8.2)*
- Utilize FRN funding for state's share for 1115 SUD Waiver, room and board, and uncompensated care *(Priority Score: 8.0)*

Objective 4.2.2: Increase Effective Utilization of Telehealth

Activities:

- Partner with a TeleMAT service provider *(Priority Score: 12.5)*
- Increase provider training and education on the effective use of telehealth *(Priority Score: 12.0)*

Strategy 4.3: Increase Availability of and Access to MOUD

Objective 4.3.1: Increase the Volume of Waivered Prescribers of Medications for Opioid Use Disorder (MOUD) Providing Treatment in Rural and Underserved Areas

Activities:

- Incentivize providers for Office-Based Opioid treatment (OBOT) through bonuses *(Priority Score: 13.5)*
- Implement a plan for expansion of mobile MOUD treatment for rural and frontier communities *(Priority Score: 13.3)*
- Monitor the capacity of SUD and OUD treatment providers *(Priority Score: 12.7)*
- Expand statewide Patient-Centered Opioid Addiction Treatment (PCOAT) model *(Priority Score: 9.2)*

Objective 4.3.2: Increase Access to MOUD

Activities:

- Create street outreach teams to provide street medicine programs, harm reduction, psychiatry, and care management *(Priority Score: 12.2)*
- Expand access to long-acting buprenorphine medications *(Priority Score: 11.8)*
- Increase education, adoption, and support for buprenorphine as a first-line treatment for reproductive/birthing/pregnant, etc., patients *(Priority Score: 10.7)*
- Initiate buprenorphine in the emergency department and during inpatient stays *(Priority Score: 10.0)*
- Expand access to MOUD treatment for youth in primary care and behavioral health settings *(Priority Score: 9.8)*
- Support low threshold prescribing for buprenorphine treatment *(Priority Score: 9.7)*
- Fully implement Nevada's hub-and-spoke system for MAT regardless of payer *(Priority Score: 11.7)*

Objective 4.3.3: Increase Provider Proficiency in Treatment with MOUD

Activities:

- Expand use of Project ECHO® to increase provider capacity *(Priority Score: 9.3)*
- Establish addiction medicine fellowships *(Priority Score: 8.3)*

- Create a provider forum for treatment and other resource-sharing *(Priority Score: 8.0)*

Strategy 4.4: Increase Treatment for Neonatal Abstinence Syndrome (NAS)

Objective 4.4.1: Screening, Intervention, and Referral for Pregnant Women

Activities:

- Offer parenting programs and home visits for at-risk pregnant women *(Priority Score: 10.2)*
- Establish SBIRT in OBGYN offices and engage Project ECHO *(Priority Score: 9.2)*
- Continue to monitor and expand ASTHO programs for Neonatal Abstinence Syndrome (NAS) with special attention to preventing health disparities *(Priority Score: 11.3)*

Goal 5: Implement Recovery Communities across Nevada

Social Determinants of Health (SDOH) include financial resources, social and community factors, education access and quality, health care access and quality, and the neighborhood and environment in which a person lives, including transportation, crime, and environmental quality. Recovery Communities take a holistic view that includes SDOH as an integral part of maintaining recovery and living successfully in the community. They provide connections to treatment and services for individuals in recovery to reintegrate into the community with better chances of maintaining recovery.

Strategy 5.1: Address Social Determinants of Health

Objective 5.1.1: Screen and Connect people to Social Determinants of Health (SDOH) Resources

Activities:

- Incorporate screening for standard SDOH needs as a routine intake procedure for all services *(Priority Score: 9.8)*
- Expand 211 to identify and match individuals to resources for SDOH *(Priority Score: 11.7)*
- Identify opportunities for faith-based organizations to provide recovery supports in local communities *(Priority Score: 8.0)*
- Include recovery support services such as recovery centers in the work of local community coalitions *(Priority Score: 8.0)*

Objective 5.1.2: Access to Housing

Activities:

- Develop housing and recovery supports for homeless youth with OUD *(Priority Score: 9.0)*
- Establish policies and funding to support evidence-based recovery housing *(Priority Score: 8.5)*
- Provide tenancy supports for individuals to maintain housing through the recovery process *(Priority Score: 9.0)*
- Develop sober and affordable housing resources through partnerships *(Priority Score: 9.0)*

Objective 5.1.3: Employment Supports

Activities:

- Develop employment supports for those in treatment and in recovery *(Priority Score: 8.7)*
- Provide education for employers through Recovery Friendly Workplace Initiative *(Priority Score: 14.2)*

Objective 5.1.4: Access to Childcare

Activity:

- Expand access to childcare options for families seeking treatment/recovery supports *(Priority Score: 9.2)*

Objective 5.1.5: Access to Transportation

Activities:

- Address transportation needs as a SDOH *(Priority Score: 12.0)*
- Support providers with start-up and transportation costs under Nevada's new, Medicaid-funded non-emergency Secure Behavioral Health Transport service *(Priority Score: 12.0)*

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

Access to MAT and other treatment interventions within the jails and prisons is limited, and individuals transitioning from incarceration to the community often have little or no access to treatment or care management in the community. Progress has been made through drug treatment courts and similar interventions; these opportunities are uniformly available in all criminal detention centers. More work is needed in providing treatment both in criminal

justice settings and during transitions so that people can recover from opioid use disorders and maintain their recovery in the community.

Strategy 6.1: Promote Safe Response to Opioid Use in the Community

Objective 6.1.1: Ensure Laws and Law Enforcement Agencies Do Not Deter Interventions for People in Need of Harm Reduction Interventions

Activity:

- Train law enforcement on laws to increase appropriate enforcement to protect interventions for people who have overdosed *(Priority Score: 11.5)*
- Ensure state laws do not prevent harm reduction efforts *(Priority Score: 11.5)*

Strategy 6.2: Prevent Overdose after Release from Jails and Prisons

Objective 6.2.1: Increase Access to Quality Care for Justice-Involved Individuals

Activities:

- Provide MAT in all adult correctional and juvenile justice facilities *(Priority Score: 12.7)*
- Expand drug court treatment availability and include treatment for multiple substances *(Priority Score: 9.3)*
- Monitor outcomes related to SUD treatment for the criminal justice-involved population *(Priority Score: 10.3)*

Objective 6.2.2: Support Individuals with Opioid Use History Leaving Jails and Prisons

Activities:

- Connect people leaving jails and prisons to post-release treatment, housing, and other supports as well as educate about overdose risk *(Priority Score: 13.3)*
- Educate parole and probation officers on the need for treatment, recovery, housing, and employment *(Priority Score: 12.8)*

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

Nevada has experienced serious impacts from the opioid epidemic over the last 10 years, resulting in high rates of opioid-related overdoses, increased health care utilization, escalating rates of neonatal abstinence syndrome, insufficient access to treatment, and increased family involvement within child welfare. To understand the impact of the opioid epidemic on Nevada, it is important to consider indicators of opioid use, such as prescription

monitoring, survey data, criminal justice data, and overdoses, as well as co-occurring behavioral health and comorbid physical health conditions and opioid-related utilization of EDs and hospitals. Focusing on health disparities for marginalized populations and the impact on youth within each of these areas further elucidates the impact of opioids and can offer potential solutions.

Strategy 7.1: Provide Consistent, High-Quality Data for Surveillance and Reporting

Objective 7.1.1: Improve the Quality of Toxicology Data

Activities:

- Establish a statewide forensic toxicology lab and improve funding mechanisms *(Priority Score: 9.2)*
- Support a forensic pathology training program *(Priority Score: 7.0)*
- Standardize and improve toxicology testing procedures, including more detailed reporting of demographic characteristics *(Priority Score: 9.8)*

Objective 7.1.2: Improve and Standardize Surveillance Reporting

Activities:

- Expand surveillance testing *(Priority Score: 6.8)*
- Standardize reporting and query code/logic across reporting agencies *(Priority Score: 8.3)*
- Establish minimum data set for suspected and actual overdose for use in all agencies, including demographic characteristics *(Priority Score: 11.7)*

Strategy 7.2: Increase Availability of Data for Rapid Response to Opioid Trends

Objective 7.2.1: Increase Breadth of Data Collected

Activities:

- Ensure data elements include demographic characteristics to identify and address health disparities *(Priority Score: 9.5)*
- Collect data from the poison control hotline *(Priority Score: 13.5)*
- Include demographics and methadone in the state prescription drug monitoring program *(Priority Score: 12.5)*
- Increase provider utilization of the Treatment Episode Data Set (TEDS) *(Priority Score: 8.2)*

Objective 7.2.2: Ensure Data is Shared Across Agencies and Providers

Activities:

- Implement the All-Payer Claims Database *(Priority Score: 14.7)*
- Increase Health Information Exchange (HIE) data sharing and utilization when prescribing opioids *(Priority Score: 8.8)*
- Create an Automated Program Interface (API) connection to Emergency Medical Services (EMS)/Image Trend *(Priority Score: 13.5)*

Objective 7.2.3: Provide Immediate Access to Critical Opioid-Related Data

Activities:

- Provide access to real-time SUD and OUD reports from various systems (e.g., EHR, PDMP, HIE, etc.) *(Priority Score: 7.8)*
- Facilitate prompt “bad batch” communications *(Priority Score: 15.5)*
- Connect public safety and local overdose spike monitoring agencies *(Priority Score: 12.0)*

Section 8
Next Steps

This 2022 Needs Assessment and Statewide Plan serves as a first version that will be reviewed and revised a minimum of every four years, or more frequently as needed. Revisions will reflect ongoing efforts to allocate and coordinate funding for opioid-related projects. The report will be distributed through the SURG and ACRN. As more funding is available from various sources and as Nevada's needs change over time, the State will update the Plan and priorities to ensure they are data-driven. The DHHS will also provide annual publicly available reports of all funding allocations and program activities to the State legislature.

Development of Detailed Work Plans

The Statewide Plan outlines broad activities that will be further developed and specified into a work plan format by Nevada's subject matter experts. The detailed work plans will be created by local experts according to the implementation priorities identified by the Nevada DHHS, based on available funds. Future changes to the Statewide Plan or changing state needs may result in additional work plans or activities.

Work plans developed by subject matter experts will incorporate detailed program or project information, list any alternative funding sources, establish start and end dates, and provide outcome measures for each activity. This includes ensuring that baseline data is established for quality assurance and measurement of the success of program activities. All activities must address disparities or potential disparities in marginalized populations and be evidence-based, nationally informed, or considered best practices for substance use prevention, treatment, recovery efforts, public health, and data surveillance.

Focusing on Health Equity

Although data on health disparities is lacking, the current evidence suggests that significant disparities do exist across the state. The availability of funds to expand current programs or support new efforts serves as a prime choice point where Nevada can be intentional about addressing disparities in marginalized populations. The Nevada Office of Minority Health and Equity (NOMHE) has developed a Health Equity Guide which models how to apply the equity lens known as "Choice Point Thinking" to develop and prioritize activities to ensure equitable outcomes. Choice Point Thinking is a commitment to develop equitable outcomes by using a conscious decision-making process. To apply Choice Point Thinking, one should identify all decision-making opportunities and examine available choices. Developing a habit of asking questions such as "Who benefits from this decision?" and "How can the people that are most impacted by this decision be included in this process?" is one way to ensure the equitable distribution of opioid settlement or bankruptcy recoveries. Use of the Choice Pointe Thinking model is essential in the further development of specific activities implemented under the Statewide Plan.

Implementing Evidence-Based Practices

As part of the fulfillment of the first and second principles of the Johns Hopkins Principles for the Use of Funds, spending money to save lives and using evidence to guide spending, Nevada will utilize the below resources in future work to identify best practices and evidence-based programs that fulfill the goals and objectives in this plan. Not all potential solutions have available evidence, so any programs or activities selected without an evidence base should implement a robust quality improvement structure so that the state can routinely monitor outcomes and the effectiveness of the investment. All programs and activities should be actively monitored for outcomes regardless of the amount of evidence available.

Resources for Evidence-Based and Best Practice Models

The following resources are available for the development of the implementation work plans under the objectives in the Statewide Plan.

Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices Resources Center

https://www.samhsa.gov/resource-search/ebp

The SAMHSA Evidence-Based Practices Resource Center "… aims to provide communities, clinicians, policy-makers, and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings. The Resource Center contains a collection of scientifically based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources."

Brandeis Opioid Resource Connector

https://opioid-resource-connector.org

"The Opioid Resource Connector assists communities in mounting a comprehensive response to the opioid crisis. It is a product of Brandeis Opioid Policy Research Collaborative. [They] provide a curated collection of community-focused programs, tools, and resources to help stakeholders choose, design, and implement essential interventions."

Primer on Spending Funds from the Opioid Litigation: A Guide for State and Local Decision Makers

https://opioidprinciples.jhsph.edu/wp-content/uploads/2022/04/Primer-on-Spending-Funds.pdf

The Primer on Spending Funds from the Opioid Litigation provides resources for each of Johns Hopkins' nine core abatement strategies.

Evidence-Based Strategies for Abatement of Harms from the Opioid Epidemic

https://www.lac.org/resource/evidence-based-strategies-for-abatement-of-harms-from-the-o

"Jointly produced by several national addiction experts, this comprehensive report contains recommendations and evidence-based strategies for the investment of litigation settlement and bankruptcy funds to end the opioid crisis and mitigate future harms."

Ensuring Accountability and Sustainability

The Statewide Plan establishes a system of accountability for the implementation of programs and services needed in Nevada by targeting the priorities established by the Needs Assessment (Sections 3 through 6). The Statewide Plan sets forth the activities to prepare the State's infrastructure to distribute and oversee the resulting programs and services, including performance review, quality assurance, and fiscal compliance. This ensures funds disbursed are used for the purposes established in the Needs Assessment, that they do not supplant other funds or program activities, and that they comply with the settlement and bankruptcy agreement requirements listed in Appendix E. Additionally, policies and procedures on the administration of the Fund for Resilient Nevada can be found in Appendix F. This ensures compliance with the funding sources, maximizes the appropriate use of funds, and monitors cost-benefits to the community.

In response to preliminary Needs Assessment findings and anticipating the need for infrastructure to support accountability and sustainability, six positions were created to administer the FRN. The six positions include a Senior Physician, one clinical program planner, one quality assurance specialist, one management analyst, one program officer, and one administrative assistant. Another two positions including a biostatistician and a public information officer have been requested separately. These positions will support the management and oversight of the Needs Assessment, Statewide Plan, and subsequent sub awards or contracts to address the impacts, risks, and harms of opioid use disorder and other substance use disorders.

To ensure fiscal accountability, existing programs and funding sources were and continue to be identified and evaluated. The Fund for a Resilient Nevada Unit (FRNU) is currently mapping the use and availability of all the State and Federal opioid and substance use funds. The map will serve as a consolidated document of programs that exist and highlight those activities that require funding. As part of this review, all money recovered or anticipated to be recovered by county, local, or Tribal governmental agencies through judgments, settlements or bankruptcies 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 are being analyzed.

Allocation Plan for the Fund for a Resilient Nevada

Fund for a Resilient Nevada

The Statewide Plan sets out the goals and strategies for the implementation of programs and services potentially funded by the Fund for a Resilient Nevada and other funding sources. The FRN was created during the 81st (2021) Session under Senate Bill 390 and codified in Nevada Revised Statutes (NRS) 433.712 through 433.744. Under NRS 433.732, section 4, "...the Director of the Department may submit to the Interim Finance Committee a request for an allocation for administrative expenses from the Fund..." and "The annual allocation for administrative expenses from the Fund must not exceed 8 percent of the money deposited..." or the maximum allowable for recoveries. FRN monies are deposited through the Attorney General's Office from recoveries from opioid litigation, settlements, and bankruptcies. The allocation of funds to state mitigation programs under the FRN is limited by the availability of

recoveries. The Fund for Resilient Nevada is the State's share of recoveries and must be used to address the risk, harms, and impacts of the opioid crisis on the state.

In another settlement and bankruptcy recovery-based funding opportunity under the One Nevada Agreement, more local allocations to all signatories to the agreement will become available. Signatories include all Nevada Counties and all litigating cities, districts, and municipalities. Many tribal governments also have their separate opioid litigation and may receive their own recoveries through settlements or bankruptcies.

Should the State determine that mitigation of the opioid crisis needs to involve partnerships with regions, counties, or tribes, or through agreements with local community programs beyond the One Nevada Agreement, the State has the statutory authority, but is not required, to provide funding through grants. Such grants will be at the direction of the State to ensure work is conducted on behalf of the State and procurement requirements as established in NRS 433.740 must be upheld.

The State recognizes the successful abatement of the opioid crisis will require the whole of both state and local resources and cooperation. To this end, the State will ensure local governments have access to the Nevada Needs Assessment, Statewide Plan, and technical support to direct their own funding to address the crisis at the local level. Use of the funds by state and local governments must be in accordance with, at minimum, the terms of the court orders, settlement and bankruptcy agreements, the One Nevada Agreement, and State laws.

Proposed Budget Allocations for Statewide Plan Goals

Estimates for proposed budget allocations are presented below according to the Goals set forth in the Statewide Plan. Amounts may change based on needs and fund availability.

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

Proposed funding estimates: FY23 $1,463.000 FY24 $1,674,700 FY25 $1,694,941

Goal 2: Prevent the Misuse of Opioid

Proposed funding estimates: FY23 $500,000 FY24 $2,185,000 FY25 $2,100,000

Goal 3: Reduce Harm Related to Opioid Use

Proposed funding estimates: FY23 $140,000 FY24 $140,000 FY25 $140,000

Goal 4: Provide Behavioral Health Treatment

Proposed funding estimates: FY23 $1,700,000 FY24 $1,500,000 FY25 $1,500,000

Goal 5: Implement Recovery Communities across Nevada

Proposed funding estimates: TBD

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

Proposed funding estimates: TBD

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

Proposed funding estimates: FY23 $361,149 FY24 $743,597 FY25 $520,025

Section 9

Acknowledgments

This Nevada Opioid Needs Assessment and Statewide Plan was prepared by Mercer for the State of Nevada Department of Health and Human Services and the Advisory Committee for a Resilient Nevada, with funding from the Fund for Resilient Nevada. The report is a result of generous input and support by numerous stakeholders, listed below, who identified opioid-related priorities, provided or evaluated data, provided insight, and reviewed methods and content of the report.

Advisory Committee for a Resilient Nevada

Center for the Application of Substance Abuse Technologies, University of Nevada, Reno

Director's Office, Nevada Department of Health and Human Services

Nevada Attorney General's Office

Nevada Minority Health & Equity Coalition at University of Nevada, Las Vegas, School of Public Health

Nevada Office of Minority Health and Equity

Nevada Substance Use Response Working Group

Office of Public Health Investigations and Epidemiology, Department of Health and Human Services, Nevada Division of Public and Behavioral Health

Office of Analytics, Nevada Department of Health and Human Services

Senior Advisor on Behavioral Health, Nevada Department of Health and Human Services

Social Entrepreneurs, Inc.

Southern Nevada Health District

Appendix A
Data Sources

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 nonfatal 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 A1.1.

Table A1.1: 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.[269]	• NSSP data is only available from 80% of the state's hospitals • The data system only captures non-fatal overdoses that made it to the ER • 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 Registry System to report on overdose mortality in the state. This source relies on ICD-10 codes.	• Average 2–3-month delay after the death investigation to receive cause and manner of death data • Use of ICD-10 codes that group multiple opioids together, making it difficult to separate specific opioids that may have been attributed to deaths • 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	• Reporting delays due to time required to abstract data from death records • Incomplete data due to reliance on information documented at the time of death

Source	Description	Limitations
	that may be associated with a fatal overdose.[270]	
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).	• Disconnect between EMS transport records and hospital care • 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 • Lack of an automated interface with ImageTrend

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.

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 may also vary, which does not allow for true comparison and aggregation of results. No data set is perfect, and there is always a trade-off between timeliness and accuracy, which could be the reason similar data is calculated differently. High-quality data takes time to accurately collect, validate, and appropriately analyze. The quality assurance process can hinder programs that need data quickly to respond to changes in the system. There is some data that is available more quickly, but it has often not yet been adequately validated. This data can be used when immediate information is needed, but it is always important to go

back and check assumptions once the complete and validated data is available. The State will need to balance timeliness with accuracy based on the monitoring needs for each program. While data are available for the rates of opioid and benzodiazepine prescription within Nevada, limited data are available for other drugs being co-prescribed with opioids. There is also a lack of demographic information about those receiving opioid prescriptions such as race/ethnicity and indicators of membership in special populations. While PDMP also tracks high-volume prescribers, analytics are not made available to understand factors behind high-volume prescribing or the changes in prescribing habits following notice from the PDMP.

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.[271] This effort may help to reduce the gaps currently being seen regarding data.

p/NELIS/REL/81st2021/Bill/7216/Overview" https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7216/Overview

Appendix B
Reference Documents

Below is a list of the reference documents that were used to develop this report.

- Alegria, M.I., 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).
- Alexander, G.C., Frattaroli, S., Gielen, A.C., 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
- Assembly Bill 239. (2019). Available at: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6425/Overview
- Assembly Bill 236_EN. (2019). Available at: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6419/Overview
- Assembly Bill 310. (2019). Available at: https://nvdoctors.org/wp-content/uploads/AB310-Legislative-Report-.pdf
- Assembly Bill 374. (2021). Available at: https://www.leg.state.nv.us/Session/81st2021/Bills/AB/AB374.pdf
- Assembly Bill 474. (2017). Available at: https://www.nvopioidresponse.org/wp-content/uploads/2019/04/opioid-compendium-of-resources.pdf
- 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).
- Bryant, D. J., Coman, E. N., & Damian, A. J. “Association of adverse childhood experiences (ACEs) and substance use disorders (SUDs) in a multi-site safety net healthcare setting,” *Addictive Behaviors Reports*, Volume 12 Issue 100293 (2020).
- CARE Coalition. *Comprehensive Community Action Plan*. 2019.
- Casado, F. “Cases of babies born with syphilis rise in Nevada in 2020.” Kolo TV, April 19, 2022, accessed May 2, 2022. Available at: https://www.kolotv.com/2022/04/19/cases-babies-born-with-syphilis-rise-nevada/
- Centers for Disease Control and Prevention. “About Social Determinants of Health (SDOH),” accessed May 2022. Available at: https://www.cdc.gov/socialdeterminants/about.html

- Centers for Disease Control and Prevention. “Drug Overdose, About OD2A.” Available at: https://www.cdc.gov/drugoverdose/od2a/about.html
- Centers for Disease Control and Prevention. “Drug Overdose, U.S. State Opioid Dispensing Rates, 2020.” Available at: https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html
- Centers for Disease Control and Prevention. “High-Risk Substance Use Among Youth,” 2020. Available at: https://www.cdc.gov/healthyyouth/substance-use/index.htm
- Centers for Disease Control and Prevention. “Persons who Inject Drugs: Infections Diseases, Opioids, and Injection Drug Use.” Available at: https://www.cdc.gov/pwid/opioid-use.html#:~:text=A%20deadly%20consequence%20of%20the,cause%20heart%20infections%20(endocarditis%20)
- Centers for Disease Control and Prevention. *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*, 2019. Available at: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf
- Centers for Disease Control and Prevention. “Sexually Transmitted Disease Surveillance 2019, Table 40. Congenital Syphilis — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2019.” Available at: https://www.cdc.gov/std/statistics/2019/tables/40.htm
- Centers for Disease Control and Prevention. “Sexually Transmitted Disease Surveillance 2020, Table 20. Congenital Syphilis — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2020.” Available at: https://www.cdc.gov/std/statistics/2020/tables/20.htm
- Cerda, M., Santaella, J., Marshall, B. D., Kim, J. H., & Martins, S. “Nonmedical Prescription Opioid Use in Childhood and Early Adolescence Predicts Transitions to Heroin Use in Young Adulthood: A National Study,” *Journal of Pediatrics*, Volume 167 Issue 3 (2016), pp. 605-12. e1-2.
- Churchill Community Coalition. *Churchill Community Coalition Comprehensive Community Prevention Plan*, 2018.
- County Health Rankings & Roadmaps. “Proper drug disposal programs,” 2017. Available at: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/proper-drug-disposal-programs
- Crime and Justice Institute, Nevada Sentencing Commission Presentation: “Impact of COVID-19 on Nevada’s Prison Population: Project Update,” September 2021.
- Davis, M.A., Lin, L.A., Liu, H. & Sites, B.D. “Prescription opioid use among adults with mental health disorders in the United States,” *Journal of the American Board of Family Medicine*, Volume 30 Issue 4 (2017), pp. 407–417.
- Diedrick, M., Lensch, T. Zhang, F., Peek, J., Clements-Nolle, K., Yang, W. *State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. 2019 Nevada High School Youth Risk Behavior Survey (YRBS) Report.*

- Felitti, V. J., Anda, R. F., Nordenberg, M. C., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine*, Volume 13 Issue 4 (1998), pp. 245–258.
- Girouard, M., Goldhammer, H., Keuroghlian, A. "Understanding and treating opioid use disorders in lesbian, gay, bisexual, transgender, and queer populations," *Substance Abuse*, Volume 40 Issue 3 (2019), pp. 335–339
- Goldner EM, Lusted A, Roerecke M, Rehm J, & Fischer B. "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*, Volume 39 Issue 3 (2014), pp. 520–531.
- Goldstick, J. E., Cunningham, R. M., & Carter, P. M. "Current Causes of Death in Children and Adolescents in the United States," *New England Journal of Medicine*, Volume 386 (2022), pp. 1955–1956.
- Griswold, T., Packham, J., Warner, J., & Etchegoyhen, L. *Nevada Rural and Frontier Health Data Book — Tenth Edition.* University of Nevada, Reno, 2021.
- Hartnett, K., Jackson, K., et al., "Bacterial and Fungal Infections in Persons Who Inject Drugs – Western New York, 2017" *MMWR Morb Mortal Wkly Rep*, Volume 68 Issue 26 (2019), pp. 583–586. Available at: https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6826a2-H.pdf
- Harvard Medical School, Blavatnik Institute for Health Care Policy. *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic*. Available at: https://www.lac.org/assets/files/TheOpioidEbatement-v3.pdf
- Health Resources & Services Administration Health Workforce. "Behavioral Health Workforce Projections," accessed April 2022. Available at: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health
- Healthy Communities Coalition Lyon and Storey Counties. *Comprehensive Community Prevention Plan 2019–2021*.
- Impact and Frontier Community Coalition. *Comprehensive Community Prevention Plan 2020–2023*.
- Johns Hopkins Bloomberg School of Public Health. *Primer on Spending Funds from the Opioid Litigation: A Guide for State and Local Decision Makers,* 2021.
- Johns Hopkins School of Public Health. *Principles for the Use of Funds from the Opioid Litigation,* 2021. Available at: https://opioidprinciples.jhsph.edu/wp-content/uploads/2021/01/Litigation-Principles.pdf
- Johnson, J., Pulver, K., and Ross, J. *SNOAC Community Vision Board: Report Compiled Based on SNSMOPS World Café Community Session*, 2021.

- Join Together Northern Nevada. *Comprehensive Community Prevention Plan for Washoe County 2020–2022*.
- Kaiser Family Foundation. "Mental Health Care Professional Shortage Areas (HPSAs)," accessed for September 30, 2021. Available at: https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22desc%22%7D
- Keyes KM, Rutherford C, Hamilton A, Barocas JA, Gelberg KH, Mueller PP, Feaster DJ, El-Bassel N, Cerdá M. "What is the prevalence of and trend in opioid use disorder in the United States from 2010 to 2019? Using multiplier approaches to estimate prevalence for an unknown population size." *Drug and Alcohol Dependence Reports,* Volume 3, 100052 (2022).
- Larney S, Tran LT, Leung J, Santo T Jr, Santomauro D, Hickman M, Peacock A, Stockings E, Degenhardt L. "All-Cause and Cause-Specific Mortality Among People Using Extramedical Opioids: A Systematic Review and Meta-analysis," *JAMA Psychiatry*, Volume 55 Issue 5 (2020), pp. 493–502.
- Larson Institute/Nevada Overdose to Action. *2020 Hispanic/Latinx Overdose*, 2021.
- Longo, D. "Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies," *New England Journal of Medicine*, Issue 374 (2016), pp. 1253–1263. Available at: https://www.nejm.org/doi/pdf/10.1056/NEJMra1507771?articleTools=true
- McCarthy, N., Baggs, J., See, I., Reddy, S.C., Jernigan, J.A., Gokhale, R.H. & Fiore, A.A. "Bacterial Infections Associated with Substance Use Disorders, Large Cohort of United States Hospitals, 2012–2017." *Clinical Infectious Diseases*, Volume 71 Issue 7 (2020), pp. e37–e44. Available at: https://academic.oup.com/cid/article/71/7/e37/5697426
- McClellan C, Lambdin BH, Ali MM, Mutter R, Davis CS, Wheeler E, Pemberton M, Kral AH. "Opioid-overdose laws association with opioid use and overdose mortality," *Addict Behav*, Volume 86 (2018), pp. 90–95.
- Mental Health America. "The State of Mental Health in America," 2021. Available at: https://mhanational.org/issues/state-mental-health-america
- Monroy, E. *Nevada Public Health Crisis Response: Final Performance and Evaluation Report*, 2020
- National Institute on Drug Abuse. *Common Comorbidities with Substance Use Disorders Research Report,* 2020.
- National Institute on Drug Abuse. *Part 1: The Connection Between Substance Use Disorders and Mental Illness*, 2021. Retrieved from https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness
- National Institute on Drug Abuse. "Substance Use and SUDs in LGBTQ* Populations." Available at: https://nida.nih.gov/drug-topics/substance-use-suds-in-lgbtq-populations

- 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.
- Nevada HIDTA Investigative Support Center. *2021 Threat Assessment*, 2021
- Nevada Institute for Children's Research and Policy. "Overdose Data to Action: Year 1 Progress Report."
- 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.
- Nevada Institute of Children's Research and Policy, University of Nevada, Las Vegas. *Care Coalition Comprehensive Community Substance Abuse Prevention Plan 2020–2021*, 2019
- 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.
- Nevada Overdose to Action and University of Nevada Public Health Training Center, Johns Hopkins Bloomberg School of Public Health. *Recommendations: Current Efforts in Nevada — Summary*, 2021.
- Nevada Overdose to Action and University of Nevada School of Community Health Sciences. *Nevada's Overdose Landscape Presentations*, July 7, 2021.
- Nevada Prescription Drug Monitoring Dashboard. Available at: https://app.powerbigov.us/view?r=eyJrIjoiYjgyYzkyMzctNDg0OS00ZGY1LWJiMWYtM2E0NdlkZjI0MmEyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9
- Nevada Public Health Foundation, State of Nevada Department of Health and Human Services, and PACT Coalition. *Final Report of Nevada's Summit Proceedings*, 2019.
- 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.
- Nevada State Opioid Response. *Nevada State Unintentional Drug Overdose Reporting System Polysubstance Report, 2019–2020 — Statewide*, 2019. Available at: https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors-polysubstance-report-2019-2020.pdf
- NRS 433.736. "Requirements and procedures for statewide needs assessment." Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec736
- NyE Communities Coalition. *Comprehensive Community Prevention Plan, Nye, Lincoln & Esmeralda Counties, 2018–2021*.

- Overdose Detection Mapping Application Program by Nevada Counties. (2021). Accessed February 2022. Available at: https://odmap.net:4443/
- PACE Coalition Serving Elko, Eureka, and White Pine. *Comprehensive Community Prevention Plan 2020–2023.*
- PACT Coalition. *2019–2021 Comprehensive Community Substance Abuse Prevention Plan.*
- Partnership Carson City. *Comprehensive Community Prevention Plan 2019*.
- Partnership Douglas County. *Douglas County's Community Prevention Plan 2019*.
- Pearce L A, Min J E, Piske M, Zhou H, Homayra F, Slaunwhite A et al. "Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: population based retrospective cohort study," *BMJ*, 2020; 368:m772.
- Public Library of Science. "Gabapentin may increase risk of fatal opioid overdose." (2017, October 3). Available at: https://medicalxpress.com/news/2017-10-gabapentin-co-use-fatal-opioid-overdose.html#:~:text=Gabapentin%20co-use%20may%20increase%20risk%20of%20fatal%20opioid,1.49%3B%2095%25%20confidence%20interval%201.18%20to%201.88%2C%20p%3C0.001%29.
- 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*, Volume 16 (2019).
- Rescigno, M., Allen, A., & Meyer, D. "Substance Use and Addiction Education for Northern Nevada Youth," *Pediatrics*, Volume 147 (2021), pp. 222–223.
- Rogers, C. J., Pakdaman, S., Forster, M., Sussman, S., Grigsby, T. J., Victoria, J., & Unger, J. B. "Effects of multiple adverse childhood experiences on substance use in young adults: A review of the literature," *Drug and Alcohol Dependence*, Volume 234 Issue 109407 (2022).
- Ruhm CJ. "Corrected US opioid-involved drug poisoning deaths and mortality rates, 1999–2015," *Addiction*, Volume 113 Issue 7 (2018), pp. 1339–1344. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29430760.
- Senate Bill 5 Overview, 2021 81st Session. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7180/Overview
- Senate Bill 40 Overview, 2021 81st Session. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7216/Overview
- Senate Bill 390 Overview, 2021. Available at: https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Overview
- Starcevich, K., Zhang, F., Clements-Nolle, K., Zhang, F., & Yang, W. University of Nevada, Reno. *2018 and 2020 Nevada Behavioral Risk Factor Surveillance System (BRFSS): Adverse Childhood Experiences (ACEs) Special Report.*

- State of Nevada Department of Health and Human Services. “Advisory Committee for a Resilient Nevada (ACRN).” Available at: https://dhhs.nv.gov/Programs/Grants/Advisory_Committees/ACRN/Home/
- State of Nevada Department of Health and Human Services. *Nevada’s Crisis Care Response System: 2020 Statewide Assets and Gaps Analysis*, 2020.
- State of Nevada 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
- State of Nevada Department of Health and Human Services Opioid Dashboard. Available at: https://app.powerbigov.us/view?r=eyJrIjoiODQ2MjJjMjktOWE5NC00MthmLTlkMmEtYzZjMDU0YWU3MmUyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9
- State of Nevada Department of Health and Human Services. *Overdose to Action Year 2 Annual Progress Report*, 2021.
- State of Nevada Department of Health and Human Services. *Perinatal Health Initiative & SUPPORT Act*, 2020.
- State of Nevada Department of Health and Human Services Prescription Drug Monitoring Program Dashboard, data for 2021. Available at: https://modi-dark.talusanalytics.com/resource/nevada-prescription-drug-monitoring-dashboard/
- State of Nevada Department of Health and Human Services. *Section 1115 Demonstration Waiver: Nevada’s Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project*, 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
- State of Nevada Department of Health and Human Services. *Suspected Nevada Drug Overdose Surveillance Monthly Report, January 2022: Statewide Report*, 2022.
- State of Nevada Department of Health and Human Services, Coordination Task Force. *2022 Operational and Planning Framework*, 2022.
- State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health. *Nevada 2020 HIV Fast Facts*, 2020.
- State of 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.
- State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health. “Statewide Epidemiology Organization (SEOW) Workgroup DRAFT MEETING MINUTES Thursday, September 16, 2021,” 2021.
- State of Nevada Department of Health and Human Services, Office of Analytics, *Nevada Vulnerability Assessment: Risk of Opioid Overdose and HIV*, January 2020.

- State of Nevada Department of Health and Human Services, Nevada Overdose to Action and Nevada Public Health Training Center. *Nevada Hospital Overdose Surveillance Quarterly Report, Quarter 2 (April 2021 to June 2021)*.
- State of Nevada Department of Health and Human Services, Nevada Overdose to Action and Nevada Public Health Training Center. *Nevada State Unintentional Drug Overdose Reporting System Polysubstance Trend Report, 2018–2019 Statewide.*
- State of Nevada Department of Health and Human Services, Nevada Overdose to Action and Nevada Public Health Training Center. *Nevada State Unintentional Drug Overdose Reporting System: Report of 2020 Deaths — Northern Nevada*, 2021.
- State of Nevada Department of Health and Human Services, Nevada Overdose to Action, Lawson Institute. *Suspected Nevada Drug Overdose Surveillance Monthly Report, October 2021: Statewide Report*, 2021.
- State of Nevada Department of Health and Human Services, Nevada State Opioid Response, University of Nevada Center for the Application of Substance Abuse Technologies. *Nevada State Opioid Response Grant Annual Progress Report*, 2021.
- State of Nevada Department of Health and Human Services, Office of Analytics. *Bureau of Behavioral Health Wellness and Prevention 2020 Epidemiologic Profile*, January 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
- State of 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
- State of Nevada 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
- State of Nevada Department of Health and Human Services, Office of Analytics. *Youth Suicide: Behaviors and Circumstances, Nevada, 2020*, February 2022. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Youth%20Suicide%20Behaviors%20and%20Circumstances%20Nevada%202020.pdf
- State of Nevada Department of Health and Human Services, Office of Analytics, Division of Health Care Financing and Policy. *Nevada Substance Use Disorder Data Book October 2019–March 2021*, 2021.
- State of Nevada Department of Health and Human Services, Office of Analytics, Methamphetamine and Stimulant Dashboard, data dated November 24, 2011. Available at: https://app.powerbigov.us/view?r=eyJrIjoiY2U2YzNlNmItZDI2OS00YTJlLTk2YmQtNzY1Nzk0MDFkZWMzIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

- State of Nevada Department of Health and Human Services, Office of Analytics, Nevada Overdose to Action. *Hospital-based Overdose Data*, 2021.
- State of Nevada Department of Health and Human Services, Office of Analytics, Nevada Prescription Drug Monitoring Program Nevada 2017–2022. Accessed February 2022. Available at: https://app.powerbigov.us/view?r=eyJrIjoiYjgyYzkyMzctNDg0OS00ZGY1LWJiMWYtM2E0NdlkZjI0MmEyIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9
- State of Nevada Department of Health and Human Services, Office of Minority Health and Equity. *Choice Point Thinking: A Guide to Applying Nevada's Health Equity Lens. 2022*. Available at: https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Advisory_Committees/ACRN/NOMHE's.HealthEquityLens%203_12April2022.pdf
- State of Nevada Division of Health Care Financing and Policy. *Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity*, 2021.
- State of Nevada Division of Health Care Financing and Policy. *Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report*, 2020.
- State of Nevada Division of Public and Behavioral Health. *Naloxone for Opioid Safety: A Nevada Provider's Guide to Prescribing Naloxone to Patients Who Use Opioids*, 2018. Available at: https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/opioids/naloxone_toolkit_color.pdf
- Stein, M. D., Conti, M. T., Kenney, S., Anderson, B. J., Flori, J. N., Risi, M.M., & Bailey, G. L. "Adverse childhood experience effects on opioid use initiation, injection drug use, and overdose among persons with opioid use disorder," *Drug and Alcohol Dependence*, Volume 179 (2017), pp. 325–329.
- Strickland, J.C., Havens, J.R., & Stoops, W.W. "A Nationally Representative Analysis of 'Twin Epidemics': Rising rates of methamphetamine use among persons who use opioids," *Drug and Alcohol Dependence*, Volume 1, Issue 204 (2019).
- Substance Abuse and Mental Health Agency. "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit," 2020.
- Substance Abuse and Mental Health Services Administration. *2019–2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia),* 2021. Available at: https://www.samhsa.gov/data/report/2019-2020-nsduh-state-prevalence-estimates
- Substance Abuse and Mental Health Services Administration. *2019 National Survey on Drug Use and Health: Lesbian, Gay, & Bisexual (LGB) Adults*, 2020. Available at: https://www.samhsa.gov/data/report/2019-nsduh-lesbian-gay-bisexual-lgb-adults
- Substance Abuse and Mental Health Services Administration. *A Guide to SAMHSA's Strategic Prevention Framework*, 2019. Available at: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

- Substance Abuse and Mental Health Services Administration. “Evidence-Based Practices Resource Center.” Available at: https://www.samhsa.gov/resource-search/ebp
- Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, 2021.
- Substance Abuse and Mental Health Agency. *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, 2020.
- Substance Abuse and Mental Health Services Administration. *National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)*, 2021.
- Substance Abuse and Mental Health Services Administration. “Opioid Overdose Prevention Toolkit,” accessed February 2022. Available at: https://www.samhsa.gov/resource/ebp/opioid-overdose-prevention-toolkit
- Substance Abuse and Mental Health Services Administration. *Recovery-Oriented Systems of Care Resource Guide*, 2010. Available at: https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf
- Substance Abuse and Mental Health Services Administration. *Treatment Improvement Protocol (TIP) 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders*, 2020.
- Substance Abuse and Mental Health Services Administration, Center for the Application of Prevention Technologies. “Primary, Secondary and Tertiary Prevention Strategies & Interventions for Preventing NMUPD and Opioid Overdose across the IOM Continuum of Care,” (n.d.). Available at: https://cadcaworkstation.org/public/DEA360/Shared%20Resources/Root%20Causes%20and%20other%20research/Crosswalk%20PST_USI_models%20with%20NMUPD_PDO__%20examples_9_27_2016_revised.pdf
- Tsai, A. C., Kiang, M. V., Barnett, M. L., Beletsky, L., Keyes, K. M., McGinty, E. E., Smith, L. R., Strathdee, S. A., Wakeman, S. E., & Venkataramani, A. S. “Stigma as a fundamental hindrance to the United States opioid overdose crisis response,” *PloS Medicine*, Volume 16 Issue 11 (2019), e1002969.
- University of Nevada, Las Vegas, Nevada Institute of Children’s Research and Policy. *Comprehensive community substance abuse prevention plan*, 2019.
- University of Nevada Public Health Training Center. *Overdose Data to Action: Formative research to investigate barriers and facilitators to accessing services among current and former opioid users in Nevada: Report of Key Findings and Recommendations*, April 2021.
- University of Nevada, Reno School of Medicine, *Nevada Rural and Frontier Health Data Book,* 2021.
- University of Nevada, Reno School of Public Health. *Forensic Toxicology & Nevada’s Overdose Surveillance System: Needs Assessment & Recommendations*, 2020.

- University of Washington School of Social Work. “SDRG looks at ways to prevent opioid dependence among incarcerated youth, (2021, May 17). Available at: https://socialwork.uw.edu/news/sdrg-looks-ways-prevent-opioid-dependence-among-incarcerated-youth#:~:text=Nationally%2C%20nearly%2020%25%20of%20adolescents%20and%20young%20adults,which%20is%20a%20strong%20predictor%20of%20subsequent%20re-incarcerations.
- US Department of Health and Human Services, Office of the Surgeon General. *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health*, 2016. Available at: https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf
- US Department of Labor, “Risk Factors for Opioid Misuse, Addiction, and Overdose.” Available at: https://www.dol.gov/agencies/owcp/opioids/riskfactors
- Welty, L., Harrison, M., Abram, K., et. Al. “Health Disparities in Drug and Alcohol-Use Disorders: A 12-year Longitudinal Study of Youths After Detention,” *American Journal of Public Health*, Volume 16 (2016), pp. 872–880.
- Wilson, N., Mbabazi, K., Puja, S., “Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018,” *MMWR Morb Mortal Wkly Rep*, Volume 69 (2020), pp. 290–297. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm
- Zhu, Y., Mooney, L.J., Yoo, C., Evans, E.A., Kelleghan, A., Saxon, A.J., Curtis, M.E., & Hser, Y. “Psychiatric comorbidity and treatment outcomes in patients with opioid use disorder: Results from a multisite trial of buprenorphine-naloxone and methadone,” *Drug Alcohol Dependence*, Volume 228 (2021).

Appendix C
Prior Work Toward Johns Hopkins Best Practice Recommendations

The State has been working to develop interventions that align with key areas of the Johns 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.

In 2017, the John's Hopkins Bloomberg School of Public Health published the report *The Opioid Epidemic, From Evidence to Impact*.[272] 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

The following table is a summary of Nevada's current efforts and alignment with the Johns Hopkins Recommendations.

[272] 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 C1.1. 2019 Nevada Public Health Training Center, Johns 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. • 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. • 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. — 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 who 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 that neighboring state.

Recommendation	Current Efforts
Standardizing Clinical Guidelines	
• Work with state medical boards and other stakeholders to enact policies reflecting the CDC's Guideline for Prescribing Opioids for Chronic Pain.	• AB 474/AB 239 (2017) were passed to ensure patients have the opportunity to discuss treatment options with their providers. Also mandates prescribers follow steps to reduce the risk associated with certain medications and provide alternative options.[273]
• Mandate electronic prescribing of opioids.	• AB 310 (2019) mandated electronic prescribing for all controlled substances prescriptions by January 1, 2021.[274]
• Standardize metrics for opioid prescriptions.	• AB 474 required 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, and 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	• 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

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

[274] Assembly Bill 310 (2019). Available at: https://nvdoctors.org/wp-content/uploads/AB310-Legislative-Report-.pdf

Recommendation	Current Efforts
or overdose and offer additional assistance and care to these patients.	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.
• 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 to help promote continuity of care.
• Improve monitoring of pharmacies, prescribers, and beneficiaries.	• PDMP identifies prescribers with concerning prescribing practices 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 Food and Drug Administration (FDA) and the Pharmaceutical Industry; therefore, they are 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 ensure that current and future national public education campaigns about prescription opioids are informed by the available	• 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 PACT Coalition on *Back to Life.*

Recommendation	Current Efforts
evidence, and that best practices are shared.	
• 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.
• 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 4 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 General 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 University of Nevada, Las Vegas, and Syndromic Surveillance. Additionally, the program is working with the State Coroner/Medical Examiners to develop reporting for suspected overdoses. • SNHD is also participating and purchased software to house a repository of data for EMS and hospitals.

Recommendation	Current Efforts
• Use federal funding for interventions to address OUDs to incentivize inclusion of outcome data in those funded programs.	• Outcome data must be reported to SAMHSA 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.
Treating OUDs	
Some recommendations were at the federal level; therefore, they are 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 stated 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 FQHCs to offer buprenorphine.	• SOR grants currently fund the Nevada Primary Care Association to expand MAT within FQHCs that are interested. All CCBHCs 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/STR has held provider education/academic detailing, as well as health care provider training. Project ECHO offered biweekly clinics on MAT. 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.

Recommendation	Current Efforts
• Incentivize initiation of buprenorphine in the ED and during hospital stays.	• Currently, SOR-funded staff is 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, they 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 can distribute naloxone for free. Nevada Medicaid FFS and MCOs cover most FDA-approved medications.
• 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 discussions on naloxone prescribing that were integrated into trainings on AB 474 in 2017 and 2018.
• Assess the effects of state laws expanding naloxone access to the public.	• Data for naloxone distribution has been collected through SOR/STR-funded programs to understand the Good Samaritan law and to whom naloxone is being distributed.
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, two of which 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

Recommendation	Current Efforts
	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 language and include evidence about the effectiveness of treatment for OUDs.	• In 2018, the Recovery Friendly Workplace Initiative began to promote individual wellness by creating work environments that support mental and physical well-being 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 were created, and SNHD provides 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.[275]

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 on should be, 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 on should be, the top three results included Treating OUDs (27%), Expanding Harm Reduction (22%), and Combating Stigma (13%).
- Priority Strategies:
  - When asked what **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 **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, include the priority strategies identified by the stakeholders, and are in alignment with Johns Hopkins Best Practices.

[275] 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 its focus on efforts at the federal level.

Appendix D
Additional Data

ACEs Data

2019 Nevada Middle School YRBS ACEs Special Report[276]

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

	Response	Total	Percentage
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%**

[276] Starcevich, K., Zhang, F., Clements-Nolle, K., Zhang, F., & Yang, W. University of Nevada, Reno. 2018 and 2020 Nevada Behavioral Risk Factor Surveillance System (BRFSS): Adverse Childhood Experiences (ACEs) Special Report.

2019 Nevada Middle School YRBS ACEs Special Report

	Response	Total	Percentage
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	Percentage
Physical Abuse	Did a parent or adult in your home beat, kick, or physically hurt you in ever hit, anyway?	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	Did anyone at least 5 years older than you or an adult, ever touch you sexually?	Yes	625	12.6%
		No	3804	87.4%
	Did anyone at least 5 years older than you or an adult, try to make you touch him or her sexually?	Yes	475	10.4%
		No	3953	89.6%
	Did anyone at least 5 years older than you or an adult, force you to have sex?	Yes	254	5.6%
		No	4179	94.4%
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	Did you live with anyone who was a problem drinker or alcoholic?	Yes	1331	27.3%
		No	3157	72.7%
	Did you live with anyone who used illegal street drugs or who abused prescription medications?	Yes	642	14.4%
		No	3842	85.6%
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%**

Appendix E

Approved Uses for Opioid Remediation

The following opioid abatement and remediation lists were taken from the National Opioid Abatement Trust (NOAT) Documents:

- NOAT - Schedule B - Approved Uses
- NOAT II - Schedule B - Approved Uses
- Distributors - Schedule E - Remediation Uses
- NOAT - Schedule A - Core Strategies
- NOAT II - Schedule A - Core Strategies

All settlement and bankruptcy recoveries in the Fund for a Resilient Nevada must be used for one or more of the following approved opioid abatement purposes:

- Naloxone (or opioid antagonist) or other FDA-approved drug to reverse opioid overdoses:
  - Expand training for first responders, schools, community support groups, and families.
  - Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.
- Medication-Assisted Treatment (MAT) distribution and other opioid-related treatment:
  - Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service.
  - Provide education to school-based and youth-focused programs that discourage or prevent misuse.
  - Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders.
  - Provide treatment and recovery support services, such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing, that allow or integrate medication and with other support services.
- Pregnant and postpartum women:
  - Expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to non-Medicaid eligible or uninsured pregnant women.
  - Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring opioid use disorder (OUD) and other substance use

disorder (SUD)/mental health disorders for uninsured individuals for up to 12 months postpartum.

  - Provide comprehensive wraparound services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

- Expanding treatment for Neonatal Abstinence Syndrome (NAS):
  - Expand comprehensive evidence-based and recovery support for NAS babies.
  - Expand services for better continuum of care with infant-need dyad.
  - Expand long-term treatment and services for medical monitoring of NAS babies and their families.
- Expansion of warm handoff programs and recovery services:
  - Expand services, such as navigators and on-call teams, to begin MAT in hospital emergency department.
  - Expand warm handoff services to transition to recovery services.
  - Broaden scope of recovery services to include co-occurring SUD or mental health conditions.
  - Provide comprehensive wraparound services to individuals in recovery, including housing, transportation, job placement/training, and childcare.
  - Hire additional social workers or other behavioral health workers to facilitate expansions above.
- Treatment for incarcerated population:
  - Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/mental health disorders within and transitioning out of the criminal justice system.
  - Increase funding for jails to provide treatment to inmates with OUD.
- Prevention programs:
  - Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco).
  - Funding for evidence-based prevention programs in schools.
  - Funding for medical provider education and outreach regarding best prescribing practices for opioids, consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing).
  - Funding for community drug disposal programs.
  - Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

- Expanding syringe service programs:
  - Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.

Mapping of Opioid Funds in the State

To make better investments in the communities, the Director's Office is currently completing a project and fund analysis review to identify how key funding streams are invested. Project mapping and planning assists with bringing information together across agencies and departments to not only shed light on the amount of funds invested in key services, but also on how effective and aligned those investments are with priority outcomes.

Appendix F

Policies and Procedures

Nevada Department of Health and Human Services

The Fund for a Resilient Nevada
Policy and Procedure Manual

October 2021
Revised August 2022

Department of Health and Human Services
Fund for a Resilient Nevada (FRN)
400 West King Street, Suite 300
Carson City, Nevada 89703
(775) 684-4000

TABLE OF CONTENTS

THE FUND FOR A RESILIENT NEVADA
Policy & Procedure Manual

Section 1 | Administrative

1.1 Introduction

The Nevada Department of Health and Human Services (DHHS) Director's Office, Fund for a Resilient Nevada Unit (FRNU) is responsible to administer the Fund for a Resilient Nevada (FRN) and to supplement and not supplant existing funding focused on opioid use or opioid use disorder in Nevada. The FRN was created by Senate Bill (SB) 390 in the 2021 legislature and codified in *Nevada Revised Statutes* (NRS) Chapter 433, "General Provisions, Mental Health," utilizing the recoveries resulting from litigation concerning the manufacture, distribution, sale, or marketing of opioids. These categories were established in accordance with the declaration of findings issued by the Governor and Attorney General on January 24, 2019. The DHHS must ensure that all mandates are met including planning, reporting, auditing, public participation, and identifying activities that may be supported with FRN funds.

1.2 Planning Level Needs Assessments

Pursuant to selected provisions of NRS 433.712 through NRS 433.744, planning efforts are accomplished in partnership with the Advisory Committee for a Resilient Nevada (ACRN) to provide input based on the quantitative and qualitative Needs Assessment targeting priority populations. This resulted in the DHHS completing a Statewide Plan with priority areas identified by priority scores. The FRN funding will be allocated based on the Statewide Plan through budget allocation and/or through a competitive grant application process overseen by the contracted agency or FRNU. Allocations are not guaranteed and must not supplant existing funding sources, including third-party liability or billable services through the Medicaid State Manual (MSM).

Pursuant to NRS 433.734, the FRNU must conduct a statewide Needs Assessment no less than every 4 years. The statewide Needs Assessments established the framework for the Statewide Plan which prioritizes recommendations for implementation of programs, many of which will be funded by the FRN budgets each biennium. The FRNU can provide support to counties, tribal organizations, or geographic areas to support the identification of need for public entities requesting assistance.

As required by NRS 433.738, the Statewide Plan to allocate money from the Fund may include but is not limited to the following projects:

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

- Services for children and other persons in a behavioral health crisis and the families of such persons; and
- Housing for persons who have or are in recovery from substance use disorders;
- Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders;
- 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 related;
- The evaluation of existing programs relating to substance use and substance use disorders;
- Development of the workforce of providers of services relating to substance use and substance use disorders;
- The collection and analysis of data relating to substance use and substance use disorders;
- Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing, and remodeling;
- 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 not already allocated by other funding or supplanting existing funding;
- Grants to regional, county, local, and tribal agencies, and private-sector organizations whose work relates to opioid use disorder and other substance use disorders;

Pursuant to NRS 433.740 funds may be used to coordinate with and provide support to regional, local, and tribal governmental entities in conducting Needs Assessments and developing plans.

The projects described may include, without limitation, projects to maximize expenditures through federal, local, and private matching contributions. This includes expanding services as matched through Medicaid for impacts of substance use disorder.

1.3 Compliance with Internal Controls

The DHHS provides grant instructions and requirements, also known as Grant Instruction and Requirements (GIRs), for each grant award, and each recipient is mandated to comply with all state controls referenced therein. Additional internal controls may be established through state statute, the State Administrative Manual, or through a DHHS memorandum.

The *Nevada Grant Policy Manual Final 2018 (nv.gov)* sets the standards for an effective internal control system for federal and state funds. Public, private, and nonprofit grantees must adhere to established controls. Foreign-owned organizations are not eligible for funding.

1.4 Purpose of Policies and Procedures

The FRN guidance mandates certain aspects of how DHHS operates its defined role as administrators of the FRN, leaving the authority and flexibility with the DHHS Director's Office - FRNU to determine the administration of respective programs. This manual defines policies and procedures for the implementation of the FRN. Policies and procedures may be amended as necessary to ensure compliance and consistency within the program. The FRNU may designate new policies through a formal memorandum and revision, which will be posted on the website and provided to existing FRN service providers and recipients.

1.5 Legislation and Guidance

Pursuant to NRS 433.732, the Fund is created in the State Treasury. Unless otherwise required by the applicable judgment, settlement or bankruptcy, the Attorney General shall, after deducting any fees and costs imposed pursuant to an applicable contingent fee contract as described in NRS 228.111, deposit in the Fund all money received by this State pursuant to any judgment received, settlement, or bankruptcy entered into by the State.

The following legislation, guidance, and legal authority inform the FRN policies and procedures described in this manual:

- Litigation Settlement and Bankruptcy Agreements
- One Nevada Agreement
- NRS 433.712 through 433.744, "Administration of Certain Proceeds from Litigation Concerning Opioids"
- NRS 433.720 defining the Office of Minority Health and Equity
- NRS 228.1111, "Contingent fee contract with a retained attorney or law firm: Prerequisites to entry"
- NRS Chapter 353, "Public Financial Administration"
- NRS 433.716 defines an Agency which provides child welfare services
- DHHS GIRs
- Nevada State Administrative Manual (SAM)
- DHHS Statewide Plan
- Memorandum of Understanding
- Interlocal Agreements
- Work Orders or Sub award Agreements

1.6 Fund for a Resilient Nevada Unit Responsibilities

The DHHS summary of priorities and mandated activities as stated in NRS 433.732 through 433.744 includes, but is not limited to:

- Conduct an initial statewide needs assessment and develop an initial statewide plan with implementation priorities;
- Ensure the statewide needs assessment and strategic plan are updated not less than once every four years;
- Develop a proposed budget to carry out the provision of the Statewide Plan;
- Ensure compliance with all tenets of the settlement and bankruptcy agreements and allowable expenditures;
- Support health and social services activities that align with the determinants of litigation and legislatively defined priority areas to address gaps identified in community-level plans and needs assessment limited to priority areas;
- Establish policies and procedures and a plan for the use of the grant money;
- Provide administrative support to the Advisory Committee for a Resilient Nevada;
- Coordinate with and provide support to regional, local and tribal governmental entities with needs assessments and developing plans in compliance with NRS 433 to be eligible to apply for funding;
- Consider any money identified by the Attorney General's Office as recovered or anticipated to be recovered by county, local, or tribal governmental agencies through judgments received, settlements entered into, or bankruptcy proceedings as a result of litigation concerning the manufacture, distribution, sale, or marketing of opioids;

- Ensure compliance with legislative mandates for public participation in the planning and development of the FRN;
- Ensure activities are evidence-based, data-driven, and provide both quantitative and qualitative data to identify the need, which may include the evidence-based practices as identified by the Substance Abuse Mental Health Administration (SAMHSA) or the Pew Institute;
- Ensure that applications for consideration for funding include a needs assessment which provides an analysis of the impacts of opioid use and opioid use disorder on the area under the jurisdiction of the applicant that uses quantitative and qualitative data 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 the area; and
- Focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions, and special populations in the area under the jurisdiction of the applicant in coordination with the Office of Minority Health and Equity (OMHE).

The FRNU is responsible to develop policies and procedures for the administration and distribution of contracts, grants, and other expenditures to state agencies, political subdivisions of this state, private, nonprofit organizations, universities, state colleges, and community colleges as part of the FRN program. This includes the competitive proposal process.

On or before June 30 of each even-numbered year, the FRNU shall ensure the Director receives a report of the priority considerations from the ACRN that includes, without limitation, recommendations from the Needs Assessment and State Plan. With the priorities established, the FRNU will make the allocations from the Fund for Resilient Nevada available through biennium budget allocation/or a competitive grant selection subject to a comprehensive competitive review process. To ensure complete transparency, the FRNU posts all awards on its website at http://dhhs.nv.gov/grants/ and manages the process and all awards**.** The FRN award notice will be posted online and distributed through the State Grant Office and DHHS stakeholders' listserv. As part of the grant award, the FRNU will report annual evaluations of programs to which grants have been awarded.

The FRNU is responsible to provide annual reports on or before January 31 concerning the FRN programs to the Governor, the Director of the Legislative Counsel Bureau the Advisory Committee for a Resilient Nevada; the regional behavioral health policy board created by NRS 433.429, the Office of the Attorney General, and other committees or commissions as deemed appropriate by the Director of DHHS.

The reports must include:

- Funding priorities identified in the Statewide Plan;
- All funding awards;
- Annual evaluation of all program activities;
- Administrative operations;
- Committee activities; and
- Any corrective actions or recommendations for the legislature.

1.7 The Advisory Committee for a Resilient Nevada

The Advisory Committee for a Resilient Nevada (Committee) as established in NRS 433.726 through 433.730 is responsible to:

- Develop recommendations for funding based on the quantitative and qualitative state needs assessment;

- Consider health equity and identify relevant disparities among racial and ethnic populations, geographic regions, and special populations which includes without limitation: veterans; persons who are pregnant; parents of dependent children; youth; persons who are lesbian, gay, bisexual, transgender and questioning; and persons and families involved in the justice system and child welfare system in Nevada;
- Focus priorities on the need to prevent overdoses, address disparities in access to behavioral health, and prevent substance use among youth;
- Define and use an objective method to identify 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;
- Take into account the resources existing in each jurisdiction and needs;
- Hold at least one public meeting to solicit comments from the public concerning the recommendations not less than once every four years or when the needs assessment is being updated and make any revisions to the recommendations determined, as a result of the public comment received, to be necessary; and
- Prioritize recommendations based on a statewide needs assessment to update the Statewide Plan and priorities at least once every four years.

Section 2 | Fiscal Operations

2.1 Program Management

The FRNU is the work unit responsible for awarding and monitoring the use of FRN funds. The FRNU ensures accountability and provides technical assistance for social service and health-related programs. The FRNU must be assured that partners have adequate systems in place to properly administer the grant both financially and programmatically, and to provide oversight of the sub-recipients. Not all applicants will be provided funding for all potential service areas.

All funding must align with the following goals of DHHS:

- Provide cost-effective services that are accessible, available, and responsive to the needs of individuals, families, and their communities.
- Foster a service delivery system responsive to the individual and cultural diversity of the people and communities we serve.
- Provide a comprehensive and integrated system of services to promote self-sufficiency.
- Promote and protect the health, well-being, and safety of Nevada citizens and visitors through programs administered by the Department.

2.2 Program Allocations

Program allocations are also determined by NRS Chapter 433. Per NRS 433.740, allocations can be made through the Director's Office, through the typical allocation process. Should sub awards and work orders need to be distributed, the state may follow a competitive process or sole source justification. Applicants will be required to provide the results of a needs assessment that meets the requirements of NRS433.742 and a plan for the use of the grant that meets the requirements of 433.744.

Based on program allocation, the FRN, in conjunction with the department, will conduct annual evaluations of programs to which grants have been awarded. The recipient of a grant shall annually submit to the FRNU a report concerning the expenditure of the money that was received and the outcomes of the projects on which that money was spent. Monthly, quarterly, or as-needed data collection is required. Requests for reimbursement are due monthly.

A regional, local, or tribal government entity that receives a grant pursuant to paragraph (b) of subsection 2 of NRS 433.738 shall conduct a new needs assessment and update its plan no less than every 4 years as designated in NRS 433.740 through 433.744; or at the direction of the Department. The Department may coordinate with and provide support to regional, local, and tribal governmental entities in conducting needs assessments and developing plans.

The FRNU will utilize the Statewide Plan based on the Needs Assessment and complete implementation plans. This process will include stakeholder participation in the planning process. These efforts play a key role in determining how the Fund for Resilient Nevada is distributed to state agencies and partners.

Recommendations for FRN allocations are made after a careful review of all available funding to ensure no supplanting of funds, including available resources, community needs assessments, and state priorities. Recommendations are identified through the Statewide Plan and biennial state budgeting process and are open to public review and comment.

Program allocations are identified in order of priority, must be based on community needs assessments to address any gaps in services, and must be subject to the target areas below. The policies and procedures will be reviewed on a biennial basis to review legislative changes on targeted populations.

2.3 Allowable Costs

Costs must be directly associated with the requirements of NRS 433.712 through 433.744 and may not be outside the scope. The Statewide Plan may allocate money to statewide projects through legislatively approved transfers, contracts, or sub grants. The Statewide Plan may also allocate money to projects through grant awards, which will be allocated through a competitive process or a Master Service Agreement (MSA). Administrative and indirect cost methodology cannot be taken simultaneously. The FRN funds are not restricted by organization type (i.e., nonprofit, public, private organizations). The annual allocation for administrative expenses from the Fund must not exceed eight percent of the money deposited into the Fund, or the maximum allowed within the litigation. Money from the fund must also be spent on a statewide needs assessment and Statewide Plan at least once every 4 years to allocate the money in the Fund in accordance with NRS 433.738.

2.4 Prohibited Uses

Although the FRN provides flexibility to meet strategic priorities, the FRN cannot be used for any use that is not specifically identified within NRS 433.712 through 433.744 and cannot be used to supplant third-party liability from private or public partners, including Medicaid or Medicare. This includes not allowing for co-pays for allowable services. This does not include Federal Medicaid Assistance Percentages (FMAP) for expanded or enhanced programming and services.

2.5 Recovery of Funds

This section relates to the potential recovery of certain funds distributed pursuant to a grant issued by the FRN. Pursuant to NRS 433.740, if a regional, local, or tribal government entity that receives a grant later recovers money through a judgment, bankruptcy, or settlement resulting from litigation concerning the manufacture, distribution, sale, or marketing of opioids:

(a) The regional, local or tribal governmental entity must immediately notify the Department; and

(b) The Department may recover from the governmental entity an amount not to exceed the amount of the grant or the amount of the recovery, whichever is less.

As a result of this requirement, a grantee that has received such settlement or bankruptcy recoveries must notify the FRN immediately upon becoming aware of the action. The FRN will evaluate whether the situation requires a recovery of money issued pursuant to a grant from the FRN. Additionally, if through other means, the FRN learns a grantee has recovered money as identified, the FRN may initiate an action to recover such funds.

THIS SECTION WAS INTENTIONALLY LEFT BLANK

Section 3 | Program Operations

3.1 Geographic Service Area(s)

By geographical size, Nevada is the seventh largest state in the nation with a large majority of the state being vast, sparsely populated areas. Nevada's two largest counties of Washoe and Clark represent 88.9% of the state's population. The remaining 15 counties are in rural and frontier counties. The DHHS FRNU has identified the entire state as the geographic region eligible for the FRN program activities.

3.2 Eligibility Determination

The Department may choose to establish eligibility criteria. If such criteria are established for clients served by a funding opportunity, they will be published in a Notice of Funding Opportunity.

3.4 Program Records

The FRNU requires each subgrantee or contracted entity to provide a detailed plan on how the entity will be using the funding. An activity report shall be submitted monthly, quarterly, or as defined in the award. This reporting document serves as the baseline data on the performance and effectiveness of the FRN funding activities. The state reserves the right to modify the reporting based on the scope of work and provision of services or activities.

The FRNU will work with each fund recipient to ensure the performance deliverables are aligned with program activities and consistent with the documentation required to evaluate the programs.

3.5 Governing Board Responsibility, Non-Profit

The governing board of nonprofit agencies identified as subrecipients with the Department is the legal contracting entity and ultimately is responsible for its overall operation. For the nonprofit agency, the governing board is a board of directors whose main function is to establish policies and adopt rules, regulations, and bylaws consistent with the purposes of the agency. It is also responsible for resolving management issues, evaluating the executive director's performance, and functioning in an advisory capacity to the executive director.

The funding mechanism is signed by the executive director, as directed by the board, or the chairman of the board, thus obligating the board of directors or governing board financially liable for the service program described in the legal agreement. The board's responsibilities include, but are not limited to the following:

- Ensuring that all requirements of the Department relative to the Department's grant/contract are met.
- Establishing policies and adopting rules, regulations, and bylaws consistent with the purpose of the agency.
- Establishing accounting systems and fiscal controls consistent with generally accepted accounting principles (GAAP) and good business practices.
- Establishing policies prohibiting nepotism (one relative supervising another) whether between the board and the agency or within the agency itself.
- Using good judgment to avoid even the appearance of a conflict of interest.
- Ensuring active involvement in directing the agency's operations through the process of regular board meetings held by the agency's bylaws.
- Accepting liability for and resolving any costs questioned as the result of audits.

A public agency usually does not have a board of directors; however, if there is a

designated governing body, that group must assume responsibilities like those of the board in a private agency. The governing board for public agencies is established through NRS and/or the Director of DHHS.

3.6 Governing Board Responsibility, for-Profit

The chief executive officer of a for-profit entity is responsible for ensuring compliance with any contract in compliance with the regulations. The CEO must ensure that all requirements of the contract are met; ensuring that all requirements of the Department relative to the Department's contract are met. This includes but is not limited to ensuring accounting systems and fiscal controls consistent with generally accepted accounting principles (GAAP) and good business practice. By accepting a contract with the Department, the for-profit agency agrees to comply with monitoring and auditing of the program activities and funding.

Section 4 | Monitoring and Review Activities

4.1 Monitoring

The purpose of monitoring programs that receive funding from the FRN is to enhance services and strengthen the overall compliance of provider service networks with the governing regulations and policies. By pursuing this objective, the potential for future deferrals, disallowance, or adverse audit actions can be reduced. Monitoring also provides an effective early warning mechanism that identifies problem areas and motivates DHHS and the provider to take corrective actions that may avoid adverse contractual sanctions.

All for-profit, public, and non-profit grantees are subject to monitoring and review. The recipient's general operating procedures and fiscal and service records are monitored on-site to determine adherence to federal and state internal controls (refer to GIRs) and to assess the provider's oversight of the funded program and to determine the appropriateness of the services provided in comparison to the service categories approved within the FRN Statewide Plan. The emphasis in monitoring is placed on administration, efficiency, program design and implementation, customer eligibility (including reviews of outcomes), and recordkeeping. Each FRN recipient is monitored annually, which may include a desk review (conducted off-site). All funded agencies are required to submit financial reports of expenditures to the FRNU. The report is reviewed by program and fiscal staff and validated by State monitoring staff to include Quality Assurance and Compliance.

4.2 Activities for Review

FRNU serves as the administrator of the FRN and focuses on the following goals and initiatives:

- Ensure that services support the mission of DHHS and the FRN objectives.
- Ensure that services reach the targeted population.
- Ensure that services are not duplicative of services already provided by DHHS.

- Ensure that services are integrated with other services offered through DHHS.
- Ensure that efforts are made to fully utilize available resources to meet the needs of the citizens of Nevada.
- Ensure that the expenditures for services are efficient and effective, and follow state and federal laws and regulations.
- Provide ongoing program and financial technical assistance to providers regarding service provision and client participation, reporting requirements, performance outcomes, and documentation requirements.
- Monitor the cost of providing services to determine if they are reasonable for the services delivered.

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com

Responses from SURG (Terry Kerns)

1. **What gaps have you identified in community services related to opioids and opioids overdose fatalities?**

One of the biggest gaps in community services is the availability of treatment programs, both in access and number of treatment facilities. In terms of overdose fatalities, I believe the lag in data can prohibit the ability to implement timely actionable response to address what is happening currently. Overdose fatality data provides great information but when it comes weeks to months later, the particular events surrounding the death(s) is often over.

2. **What recommendations do you have to address the gaps you've identified?**

Need for more treatment providers as well as timely access. In the interim, programs such as Emergency Room bridge programs and/or mobile units can help address those who cannot get into treatment after they experience an overdose. The use of more real time data (24-72 hours) post overdese can help guide actions for outreach and notification to stakeholders to address the current problem. New York City Office of the Medical Examiner has a program that, if implemented in Clark County may help with the need for more real time data from overdose fataility. This program is RxStat. I am attaching a PDF on RxStat.

3. **If you were tasked with this responsibility, what would your first initiatives be?**

Explore ways to implement real time data gathering and distribution to stakeholders. Also implement/fund programs such as ER bridge programs and/or mobile units. Also explore programs such as waste-water testing for drugs to establish what drugs are in the system.

4. **How can we improve data collection and reporting systems to better monitor and track opioid overdose deaths?**

Use existing programs such as EMS data, hospital ER data, and ODMAP on suspected overdoses. Also explore a program such as NYC RxStat. My other suggestion is not specific to opioid overdoses but addresses all drugs. I suggest implementing a program that would test all biological samples collected in Driving Under the Influence (DUI) cases to see what impaired driving in Las Vegas really looks like. This would provide data for prevention/intervention programs. There are places in the US that currently do this such as Orange County, CA.

5. **What are the key risk factors (e.g., social determinants of health) associated with an increased risk of opioid overdose fatalities?**

Unequal access to treatment. Those who do not have Medicaid or many insurance providers do not cover SUD treatment. Also, stigma surrounding drug use and the availably

of harm reduction and fear of calling 911 for drug overdoses out of fear of arrest and/or non-compassionate overdose response.

6. **What are the most effective strategies for preventing opioid overdose fatalities, such as naloxone distribution, safe consumption sites, and medication-assisted treatment?**

All harm reduction is needed, addressing stigma, and understanding why PWUD (people who use drugs) are not calling 911 for care during/after an overdose. Also prevention activities that keep people from starting drugs.

7. **How can we improve access to and utilization of promising and evidence-based harm reduction interventions, particularly among high-risk populations?**

Decreasing stigma, target high-risk populations based on near real time data and get more people/places where overdoses occur to train staff and carry naloxone.

8. **How can healthcare systems and community-based organizations better collaborate and coordinate their efforts to address the opioid crisis?**

Bring stakeholders to the table and have them involved in the process, data sharing, and innovative programs such as ER Bridge programs, free naloxone available in ERs without a prescription and going through the pharmacy (vending machines and/or peers providing naloxone to those who experienced an OD)

9. **What recommendations would you like to see in the Regional Opioid Task Force final report made to the Governor's Office and the Director of the Legislative Counsel Bureau?**

Need to implement more near real time data gathering and sharing

Implement programs based on near real time data sharing

Better access to treatment

More widespread evidence-based prevention programs

Fund programs such as ER Bridge programs and mobile units

Testing of all biological samples from DUI cases for a panel of drugs/substances

In hospital lab testing for fentanyl/analogues on suspected overdose patients. Often hospitals have to send samples to an outside lab for fentanyl testing and results are not back until after the patient is discharged.

RxStat

A public health and
public safety collaboration
for responding to problem drug
use at the municipal/county level

TECHNICAL ASSISTANCE MANUAL

RxStat

A public health and
public safety collaboration
for responding to problem drug
use at the municipal/county level

TECHNICAL ASSISTANCE MANUAL

Prepared by Daliah Heller, PhD, MPH

ACKNOWLEDGMENTS

This manual attempts to capture the wealth of knowledge and experience realized through the first two years of RxStat work in New York City and the contributions of work developed in the years prior. This manual would not exist without the commitment, cooperation, and collaboration of the many individuals involved in this work. The author gratefully acknowledges the assistance and feedback of the following individuals –

New York City Department of Health and Mental Hygiene

Daniella Bradley O'Brien, Alexandra Harocopos, Hillary Kunins, Jason Lerner, Michelle Nolan, Denise Paone, Ellenie Tuazon

New York/New Jersey High Intensity Drug Trafficking Area Program

John Hreno, Elizabeth Blythe McCoy, Chauncey Parker, Pamela Phillips Lum

Representatives from the following agencies generously gave their time to interviews towards the development of this manual –

NYC Department of Education, NYC Department of Health and Mental Hygiene, NYC Deputy Mayor of Health and Human Services, NYC Health and Hospitals Corporation, NYC Human Resources Administration, NYC Mayor's Office of Criminal Justice, NYC Special Narcotics Prosecutor, New York County District Attorney, NY/NJ High Intensity Drug Trafficking Area Program, NYS Office of Alcoholism and Substance Abuse Services, Queens County District Attorney, Richmond County District Attorney, US Drug Enforcement Administration – New York Division.

This project was supported by Grant No. 2013-PM-BX-0012 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

SUGGESTED CITATION

Heller D, Bradley O'Brien D, Harocopos A, Hreno J, Lerner J, McCoy EB, Nolan M, Phillips Lum P, Tuazon E, Parker C, Kunins H, Paone D. RxStat: Technical Assistance Manual. 2014. New York City.

Inquiries or requests for further information on RxStat should be directed to the Bureau of Alcohol and Drug Use Prevention, Care, and Treatment, NYC Department of Health and Mental Hygiene: www.nyc.gov/health

EXECUTIVE SUMMARY

RxStat is a model for advancing a shared understanding of the patterns and characteristics of problem drug use – including prescription opioid misuse – in a local jurisdiction. In New York City, RxStat was initially developed with the goal of preventing overdose mortality. RxStat uses existing datasets to generate information which can be used to tailor targeted interventions and policy responses to reduce deaths and illness involving prescription opioid and other drug misuse.

This manual is designed to support local jurisdictions in the establishment of an RxStat initiative. It is organized as a technical assistance resource and guide for creating similar initiatives in other cities and counties around the United States. This manual is informed by the first two years of experience with RxStat in New York City, where the initiative was established in 2012.

The initiative relies on the collaboration of public health and public safety agencies in a jurisdiction. RxStat incorporates data from local, state, and federal government sources and applies a public health analysis for comparing and triangulating findings across datasets. These efforts require an investment in data analysts to conduct the work, and a willingness among agencies to share data for analysis.

Section One of the manual identifies and describes key elements in the five stages of RxStat development: Basics, Getting Started, Building Content, Managing Process, and Moving Forward. This section includes practical suggestions for structuring the work and observations and examples from the New York City experience in its first two years. To develop the content for this section, interviews were conducted during late 2013 with 23 individuals who have been key players in the ongoing work of New York City's RxStat. A checklist for RxStat implementation is presented at the end of the section.

In Section Two, readers will find detailed information on each of the datasets that have proven useful to the New York City initiative, including guidance for accessing, preparing, and analyzing similar datasets available in other jurisdictions. Because RxStat relies principally on standard administrative datasets as its sources of data, it can be replicated as an initiative in other jurisdictions.

TABLE OF CONTENTS

SECTION TWO – DATASETS

FOREWORD

The RxStat initiative was established in New York City in 2012, emerging from the cross-disciplinary identification of local health and social problems related to prescription opioid misuse. The health department had observed high rates of opioid prescribing in particular neighborhoods of the city and was reporting increases in overdose deaths involving opioids in many of these same areas. Prosecutors and police were pursuing and trying cases against several local physician practices suspected of clinical malpractice.

To respond to this emerging crisis, former New York City Mayor Michael Bloomberg convened the New York City Task Force on Prescription Painkiller Abuse. The Task Force included a data work group to compile and share the public health and safety data reflecting the consequences of prescription opioid misuse in New York City, such as overdose death, prescribing patterns, and crime. Led by the New York City Department of Health and Mental Hygiene and taking the name RxStat, the data work group expanded to incorporate participants from city, state, and federal government agencies.

The formation and development of this multidisciplinary data-focused group established a platform for public health and safety collaboration. Prescription opioid misuse often occurs in the context of other drug use, and thus, RxStat also can provide insight into other problem drug use with many of the same data sources. By shaping a shared understanding of prescription opioid misuse and other problem drug use through the data, RxStat facilitates a trans-disciplinary approach to drug policy and practice innovation.

In this sense, the work of RxStat has shifted from its beginnings as an intersectoral, cross-disciplinary initiative focused on prescription opioid-involved overdose deaths to support a trans-disciplinary working group sharing and discussing data on problem drug use. “The whole is greater than the sum of the parts.”

SECTION ONE – KEY ELEMENTS

I. BASICS

RxStat brings together jurisdictional representatives from the two distinct disciplines of public health and public safety with the goal of characterizing prescription opioid use and other problem drug use in a local jurisdiction to inform policy and program interventions for preventing overdose mortality and reducing problem drug use. The process of RxStat can guide the development and implementation of tailored and measurable interventions.

1. Charge

Prescription opioid misuse is an issue that touches many different government agencies. In a single jurisdiction, information about prescription opioids is generated in many different places, such as the health department, the police department, and the medical examiner's office. Bringing together the major stakeholders allows for different perspectives on the issue and facilitates a shared, comprehensive understanding of the local patterns, characteristics, and trends associated with prescription opioid misuse.

RxStat builds a data-driven foundation to guide an integrated approach to prescription opioid and related drug policies and practices. In New York City, the initiative has organized around ***the shared goal of reducing prescription opioid misuse and related problem drug use.***

The specific measures adopted by RxStat assess the extent, severity, and heterogeneity of the problem. ***Accidental drug overdose deaths represent the leading critical indicator of this problem in the jurisdiction.*** RxStat adopts a hierarchical approach to defining and monitoring indicators; this is further described in the second section of this manual, in which the RxStat datasets are discussed in detail.

2. Framework

The RxStat initiative is grounded in a public health framework, emphasizing the use of data as a measure of patterns and trends in the population and considering drug use a health issue requiring a shared public health and safety response. Implementing this public health approach relies on a multi-disciplinary group made up of representatives from the agencies charged with protecting the health and safety of the community. Working together, this group can generate a broad, inclusive understanding of the local problems associated with prescription opioid misuse and other problem drug use. In practice, RxStat employs a public health model for analyzing and monitoring population-level indicators.

3. Jurisdiction

The experience with RxStat in New York City supports its utility and effectiveness as a municipal or county-level initiative. At this jurisdictional level, government agencies provide direct services to residents, facilitating their insight into the impact of policies and practices on community health and safety. Emergent problems can be identified in a local context, close to the ground and among a diverse group of actors, through information-sharing and data triangulation. Together, the group can compile, examine, and interpret available data and devise tailored responses to problems given agency knowledge and close experience with daily life in the jurisdiction.

The expansion of an RxStat initiative beyond the city or county microcosm, to a regional or even state-wide level, could threaten its viability as a real-time analytic and problem-solving effort. The greater the distance of representative agencies and participants from the ground and the daily lives of the jurisdiction's residents, the less connected they are to the patterns implied by the data and the implementation of localized responsive programs and policies.

II. GETTING STARTED

1. Leadership

The cohesion and focus of an intersectional jurisdictional initiative such as RxStat relies on its formal and informal leadership, as well as on the ongoing work of project coordination.

a. Catalyzing the initiative

The development of an RxStat initiative in a county or municipal jurisdiction is unlikely to happen simply because it is a "good idea." Building momentum for the initiative may be necessary to ensure sufficient buy-in for its formal establishment, and advocacy both within and among agencies can help make this happen. In New York City, the New York/New Jersey High Intensity Drug Trafficking Area (NY/NJ HIDTA*) Program worked in partnership with the city's health department to plan and initiate RxStat. Ideally, one or more individuals with standing relationships among health and/or safety agencies and networks can take on this role.

Informal dialogue can help to identify and rally individuals working in the public health and safety agencies to generate interest in RxStat and support for getting started. This approach may be particularly important to foster support from local public safety representatives, given RxStat's explicit public health framework. Preliminary outreach to ranking officials in key agencies can help prepare foundational discussions towards the formal development of the initiative.

b. Formal call to action

The mayor or county executive plays a key role in the formation of RxStat. Establishing the initiative as an ongoing formal body of the jurisdiction provides a structure for stakeholders' coming together and cooperating to share, analyze, and interpret the data, whether as a task force, a committee, or some other named working group. The leadership of the jurisdiction's top executive in this effort is of central importance for the successful convening of the group.

The distinct and often divergent roles played by the agencies responsible for the public health and safety of a jurisdiction's residents may make them unfamiliar with each other in a daily working context. Collaboration between these entities may not be routine occurrence. Even where the different disciplines find common cause – for example, standardizing coordinated responses to reported cases of sexual assault – collaboration between the agencies is usually time-limited, focused on the development and implementation of a specific plan.

---

*The NY/NJ HIDTA is funded by the White House Office of National Drug Control Policy. One of the goals of the NY/NJ HIDTA is to reduce the most harmful consequences of drug abuse, particularly drug overdose deaths. Through its Drug Trends Group, the NY/NJ HIDTA supports the efforts of local public health and public safety agencies to collect and analyze timely data on a comprehensive set of drug-use indicators, with particular emphasis on the abuse/misuse of heroin and prescription opioids.

Because representatives from the two disciplines rarely work together in a routine or ongoing fashion, the leadership of the jurisdictional authority sets expectations for collaboration. Such formal leadership is essential for motivating a commitment to a shared purpose among the group and curbing the potentially incommensurable public health and safety approaches to problem-solving.

The specific selection of participating agencies and their representation to the initiative is also the decision of jurisdictional leadership. Requiring the involvement of senior-level representatives from the governmental agencies serves to prioritize the work and gives it urgency and momentum.

In New York City, the Deputy Mayor of Health and Human Services and the city's Director of Criminal Justice formally convened a mayoral task force on prescription opioid misuse, and RxStat developed as its data working group. The conveners invited agency commissioners from city and state government to participate (or designate senior leaders to participate) in the task force and in the data working group. The conveners extended similar invitations to county prosecutors and local leadership from federal agencies.

The involvement of senior leaders signals the particular importance and value of the initiative. The visibility of this commitment can encourage leadership from other agencies, including separately elected individuals, such as prosecutors, to join and actively participate.

c. Coordination

As an ongoing, multi-agency collaboration with a considerable administrative component, RxStat relies on a centralized coordinator to provide project management. The coordinator manages meeting logistics, channels inter-agency communications, and organizes content, working with agency representatives and staff to access data and finalize presentations. The coordinator also serves in an anticipatory role, laying groundwork for upcoming meetings through informal, preparatory conversations with agency representatives behind the scenes.

The coordinator position should be based in a location to facilitate information access and exchange and where existing data-sharing and analytic expertise is housed. The coordinator may be best situated within the agency contributing the majority of the data to RxStat, likely the public health department. Alternately, the coordinator could be centrally located within the mayoral or county executive office.

2. Representation

The strength of a jurisdictional initiative such as RxStat depends on the active participation of agency representatives.

a. Who are the public health actors?

Principal agency: Public health department
Other participating agencies: Substance use disorder treatment program authority (state), hospital systems (public), prescription drug monitoring program (state), education department, emergency medical services, correctional health services, homeless services, child protection services, social services (public assistance).

b. Who are the public safety actors?

Principal agency: Police department
Other participating agencies: Prosecutors (county elected), HIDTA, drug law enforcement (federal), probation, parole, Medicaid fraud investigation.

c. Reconciling the different perspectives

The boundaries between public health and safety are sometimes blurred and overlapping, and a wide, often-divergent range of perspectives exists, even among the professions within a discipline.

In New York City, RxStat includes government actors from the county, municipal, state, and federal levels, each of whom are empowered by their respective authorities. This involvement benefits the initiative by incorporating perspectives from other levels of government but may also present a challenge, as different interests and orientations may shape each of their work agendas.

The operating strategy and keystone for RxStat collaboration is data analysis. This focus helps to overcome differences among participants because the group works in the context of data to build a shared lens and foster learning from one another's experiences.

Using data to build a trans-disciplinary approach across different levels of government helps address the complexities of responses to problem drug use. The experience of RxStat in New York City, involving a large number of agencies and perspectives, confirms that the development of this approach is feasible and yields positive outcomes.

> "We want to hear what people are saying and understand their point of view… I'd like to think that the more data-driven perspective facilitates this."
>
> *—PUBLIC HEALTH REPRESENTATIVE*

III. BUILDING CONTENT

1. Data

The practical work of RxStat involves a wide range of datasets, most of which are generated for administrative, rather than research, purposes. As a consequence, data ownership, variable selection, data collection, and information management are all organized to meet the functional needs of their agencies. Negotiating access to and use of the data represents one of the main operational hurdles for implementing RxStat.

> "Data is the glue that brings everything together."
>
> —*PUBLIC SAFETY REPRESENTATIVE*

a. Silos

The problem of separately operating silos is not new to government, but for a collaborative initiative such as RxStat, it presents a particular structural challenge. The initiative uses information from many different agencies where it is already collected, and standardizes the way it is presented for side-by-side consideration.

Although the primary datasets of interest for RxStat are held within the public health agency, they are usually collected and maintained by different offices. For example, in New York City, death data is managed by the vital statistics office, hospitalization data is maintained by the state health department, and emergency department visits are tracked and maintained principally as a monitoring tool for communicable disease. RxStat relies on effective communication and coordination with the primary owners of each dataset to establish parameters for accessing and analyzing the data.

b. Data-sharing and sensitivity

As such, data-sharing is a central issue for RxStat. Many agencies lack the capacity to analyze their own datasets, while this expertise is often well-developed in the public health department. Consequently, the need to share or transfer datasets from the ownership agency to the RxStat office is likely to arise.

The problem of identifiable data is the most common, but resolvable, data-sharing issue for RxStat. Because the initiative focuses on patterns in the data, rather than on specific individuals, all datasets are de-identified for the purposes of RxStat. Agencies may also have concerns regarding the sensitivity of specific variables in the data they gather and will need to distinguish these in relation to the variables of interest to RxStat. Finally, the potential for data misinterpretation may threaten agencies' willingness to share data. These types of concerns may need to be explicitly addressed and will help to build trust among RxStat participants.

A data use agreement can resolve concerns related to data-sharing. A standard agreement should specify that data will be de-identified prior to sharing, that the itemized, agreed-upon variables

will be shared, and that some form of penalty will be levied for any violation of the agreement or its terms by either user. Formal memoranda of understanding are sometimes needed, but such agreements can become bound up in inter-agency legal negotiations for an extended period of time, preventing the work from moving forward.

Data use agreements specify:

- de-identified data
- itemized variables
- penalty to be levied for violation

In addition, detailed data-sharing guidelines from the ownership agency for each dataset of interest can guide the development of a data use agreement. Such guidelines should include a complete codebook for the dataset and specify any exclusions for data-sharing or potential analyses, the preferred methods for addressing confidentiality issues (e.g., de-identification, encryption, HIPAA), and other issues relevant to data ownership and transfer.

Clarifying processes and expectations for data-sharing early in the development of RxStat can smooth implementation considerably. These discussions provide an opportunity to address agency and analytic concerns up front and with transparency, beginning to map analyses together in ways that will be most useful. Ideally, ownership agencies can bring sample analyses or data tables to the group for informal review and planning before data-sharing is formalized and initiated. This process can help to establish agreement on what and how data will be shared, prepared, and analyzed.

c. Methods

RxStat applies epidemiologic methods for preparing and presenting data regardless of source. While this approach is standard to public health, it is notably different from the methods law enforcement uses to examine data. For example, data available through the prescription drug monitoring program are generally used to identify patients meeting specific criteria (e.g., receiving opioid prescriptions from more than one doctor in a single month), with the goal of curbing medication misuse and diversion. By contrast, a public health analysis is concerned with the relative distribution of all opioid prescriptions by geography, patient age, frequency or quantity of prescriptions, etc.

RxStat applies population-level public health analyses to non-public health data. Law enforcement examines information at the individual level, similar to health care providers. This contrasts with an epidemiologic approach, which reports data in relationship to similar phenomena – i.e., as a proportionate value, rather than a simple number.

RxStat establishes a standard, epidemiologic approach for considering the characteristics, patterns, and trends in public safety data involving prescription opioid misuse and other

problem drug use. In this approach, public safety events are reported as a segment of a larger, similar group. For example, prescription opioid arrests during a given period as a proportion of all drug arrests during that period.

> "It's challenging because it highlights some different approaches to data that could really inform different responses."
>
> *—PUBLIC HEALTH REPRESENTATIVE*

An unexpected development of RxStat has been its energizing effect among participants for identifying and gathering new data sources. As new datasets are integrated into RxStat, analytic findings are shared and discussed in working group meetings. These findings can generate connections and, often, new ideas for data collection and analysis. The diverse perspectives and varied experiences of RxStat participants, working together in the context of the initiative, continue to yield new opportunities for further development.

d. Learning

Through presentation and discussion in regular meetings in a respectful, open environment where questions are encouraged, agency representatives learn from one another and develop a shared sense of ownership for RxStat. Agencies that are forthcoming with data inspire representatives from other agencies to initiate plans for sharing; a sense of mutual trust develops in the group.

Beyond the data, participants in RxStat learn each other's terminology and approaches. This is an issue not only for the introduction of new terms, but also when a term is differently understood in each discipline. For example, in public health, the term "key informant" refers to an individual with expert community knowledge, while in public safety, it describes someone cooperating with the prosecution in the development of a criminal case. The definitions of terms must be clearly articulated for the group, and even repeated each time a term is used, to solidify and reinforce comprehension among participants. The development of a shared lexicon for RxStat grounds the initiative in a common, pragmatic language.

RxStat participants maintain an open approach to understanding data. They welcome any new data source introduced to the group and view each dataset as contributing pieces to the puzzle of describing drug use in the jurisdiction. Participants in the New York City initiative report their experience with RxStat appreciatively, noting it has helped them to develop a multifaceted, nuanced perspective on prescription opioid misuse. They highlight the progressive group dynamic produced by meetings and report examples of learning that include the effects of problem drug use in the community, the role of opioid substitution treatment, and the relationship between drug diversion and crime.

2. Resources

a. Investment in data analysts

The basic work of RxStat is data analysis, and it cannot be accomplished without the person-power of data analysts. The agency where the initiative is housed, usually the public health department, needs expertise to conduct statistical and epidemiologic analyses, if this is not already in place. The agency may require resources to dedicate analysts to RxStat.

> "The more time we spend in RxStat, the more we realize the importance of educating people about drug addiction."
>
> *—PUBLIC SAFETY REPRESENTATIVE*

Data analysts represent an investment in the preparation, analysis, and interpretation of data. Given their keen understanding of the data, analysts play key roles in all the initiative's meetings, presenting and explaining findings for the group. Meeting discussions also give analysts the opportunity to gather ideas and feedback for conducting new analyses. Senior managers at agencies with data analyst capacity should ensure these staff can participate in RxStat.

The initiative requires a financial investment to create and fill analyst positions and to offset the costs of RxStat participation for already-existing staff. Resources are necessary to make use of existing data for RxStat, and jurisdictions seeking to replicate the initiative will need to make an investment to implement RxStat. Some agencies may need financial support to dedicate a staff member to the initiative, even on a part-time basis. In smaller communities, law enforcement might benefit from a centralized data analyst resource to prepare public safety data. In some cases, technical assistance to get the initiative going may warrant start-up support as well.

Similar agencies can pool their efforts to analyze data or rely on the best resourced among them to manage the data and conduct analyses, while the others may simply arrange for the routine transfer of specific data files. For example, in New York City, where there is a prosecutor for each of the five counties, one of these offices uses its resources to prepare the data for all five prosecutor offices; the others can simply transfer the requested files to that office each month. In rural counties with few resources, building any capacity for data analysis may present a significant obstacle to the development of RxStat.

The RxStat process may yield additional analytic and research needs, calling for additional funding. For example, agencies with extensive data sources may choose to invest in an internal data analysis unit as they consider new uses for these data through participation in the initiative. Setting up real-time quantitative analytics, such as surveillance for emergency department visits, may require additional, dedicated investment in staffing. Findings suggested by the RxStat datasets may be better understood through focused qualitative research efforts; the initiative may need funding to hire a dedicated qualitative investigator for this purpose.

b. Funding sources

There are a number of potential sources of funding for investments in data analyst staff and related RxStat costs. New York City's initiative has benefited from an initial funding investment by the NY/NJ HIDTA program, bolstered by additional resources secured through a competitive grant awarded by the federal Department of Justice's Bureau of Justice Assistance.

As a policy investment, jurisdictions could view RxStat as an initiative that will result in longer-term cost savings to local and state government services once it is fully implemented and operating. For example, drug-related costs to both law enforcement and emergency health care services may decline as the jurisdiction becomes more effective in mobilizing programmatic and policy responses to findings in the data. A portion of these projected savings could be invested in the development of RxStat in anticipation of such effects. Regardless of the source, a funding investment is essential for making RxStat work.

> "This should be a funding priority because it's an epidemic."
>
> *—PUBLIC SAFETY REPRESENTATIVE*

IV. MANAGING PROCESS

1. Structure

RxStat involves both developmental activities – gathering, preparing, analyzing, and discussing data – and reporting activities – reviewing and discussing particular findings of interest. To accomplish this parallel approach, the RxStat structure in New York City has been organized into two groups: a process-oriented working group and a formalized stakeholder group.

a. Working group

In New York City, the working group is comprised of mid-level and some senior-level staff representatives from the agencies participating in RxStat, including data analysts. The group meets on a monthly basis to review and discuss findings from analyses of existing datasets, and to identify and plan for accessing new datasets. Meeting content is treated as confidential, and participants are expected to honor and model this standard. The RxStat coordinator manages meeting logistics and tracks meeting discussions and follow-up needs as they arise.

While these meetings do follow an agenda, they serve as a sounding board for the initiative – providing a forum for brainstorming sessions to better understand the data, discuss emergent findings, and share related policy efforts or program activities. This process is particularly valuable because it builds from the knowledge of the diverse group represented in the room, reflecting the broad spectrum of public health and public safety agencies working in the jurisdiction. Participants are encouraged to ask questions, and the learning that happens in this meeting is fed back to the respective agencies. Buy-in for the process grows, and a shared comprehension of the landscape is further developed.

> "Trust is being built and relationships are being built as a result of the process of meeting every month to go over data. It's hard to put a value on that, but it's valuable."
>
> *—PUBLIC HEALTH REPRESENTATIVE*

The working group of RxStat serves as the multi-agency engine for the initiative, developing, shaping, refining, expanding, and driving the work towards the establishment and maintenance of a real-time, wide-angle view of prescription opioid misuse and other problem drug use in the jurisdiction.

b. Stakeholder group

The stakeholder group represents the public face of RxStat in New York City. Meetings involve senior-level staff representatives from the participating agencies and take place on a quarterly basis. These meetings operate more formally and involve a series of presentations by analysts, showcasing the latest findings generated through the working group and the incorporation of new datasets. The meetings are jointly chaired by RxStat leadership from the NY/NJ HIDTA and the public health department respectively, while meeting logistics are managed by the RxStat coordinator.

As a higher-level meeting, the stakeholder group creates a forum for representatives to understand the data in the context of new policies or practice initiatives. In addition, agencies that have not yet joined RxStat may join a stakeholder meeting to understand the work of the initiative and consider the role they might play as an active participant. In New York City, representatives from other jurisdictions and from state and federal agencies have participated in this meeting to learn about the work of RxStat. This group provides an opportunity to showcase findings and generate support for new policy efforts and program activities among participating agencies.

2. Participation

RxStat meetings create a space for representatives from the public health and safety agencies to interact with one another, many of whom would otherwise never meet each other at work. These introductions, in regular meetings and in small groups working on specific issues, ease personable communication and build relationships across the disciplines. As a consequence, people feel more comfortable asking questions in the meetings and learning from one another.

> "What's been helpful are not just the findings, but the process of using the data and the relationships that are built around that, and the credibility that's been built – there is then the opportunity for mutual respect, and that's really important when you're trying to make big changes."
>
> *—PUBLIC HEALTH REPRESENTATIVE*

Naturally, these relationships also expand and improve information access and sharing among RxStat participants outside of the meetings. As staff get to know one another at the meetings, they exchange contact information and offer assistance to one another. They recognize intersections and shared interests in their work and identify opportunities for collaboration and mutual benefit. Participants become more comfortable with one other, contacting each other between meetings to better understand policies, programs, or data, or to address shared issues and concerns, and all of these interactions help the work evolve. Data-sharing is simplified because participants feel

comfortable having informal conversations to discuss the most useful content for including in data requests and even prepare these requests together.

This groundwork happens between meetings, among analysts and other participants close to the data, but serves as fuel for the work of the initiative. Conversations during working group meetings or in between meetings help participants to better understand each other's perspective. The strength of inter-agency relationships in RxStat helps to rally new participation and buy-in for the work of the initiative and for engagement across the disciplines.

The benefits of relationship-building are not always tangible, nor can they be forced. The New York City experience with RxStat has demonstrated that, when there is sufficient interest, curiosity, and, particularly for representatives from the two disciplines, a shared commitment to the work, these relationships develop quite organically.

RxStat is guided by a philosophy of collaboration and the recognition that working together across disciplines on the issue of prescription opioid misuse and problem drug use can prevent participants from working at cross purposes in practice. Regular attendance at the working group meetings, the willingness to supply data when requested, and a respectful, critical learning environment among participants and across disciplines have advanced the cooperative spirit of the initiative. The combined effect of these factors provides a strong foundation for RxStat.

3. Action

a. Realizing value

The developmental experience of RxStat in New York City has resulted in an active partnership, with buy-in across the different agencies and a commitment to the bigger picture, not simply one's own role and interest in the issue. RxStat creates an environment of mutual learning and innovation among diverse agencies with little additional funding. The initiative has realized operational efficiencies by transferring knowledge and skills, adding and adapting agency-level data collection, and tailoring intervention strategies to respond to specific issues. This effect is particularly important as the budgets of municipal and county agencies continue to contract in the current economy.

Practice-sharing across disciplines has been reinforced by the publicity given to RxStat data findings. The presentation of government-generated public health and public safety data side-by-side, in a unified report on the topic of prescription opioid misuse and problem drug use, is essential for demonstrating its trans-disciplinary value. Agencies involved with RxStat have together advocated on related state policy issues and legislative efforts, effectively accessing both health and criminal justice representatives in the state executive and legislative branches. Without the RxStat partnership, such wide reach in the legislative branch would have been limited or non-existent.

These efforts reflect the power generated by developing and positioning shared work with diverse perspectives. The relationships that have developed among the agencies through RxStat represent a first step toward an integrated approach to addressing problem drug use. Simply put, "the whole is greater than the sum of its parts."

b. Events triggering coordinated investigations

While RxStat focuses on incorporating datasets for the real-time monitoring of drug-related indicators, specific drug-related events or findings may necessitate an immediate response. Before the implementation of RxStat in New York City, such events would usually have been addressed by a single agency acting alone, and information may not have been shared with others beyond that agency. With the initiative now in place, the coordinated involvement of multiple agencies can generate a rapid, comprehensive response to the event, while ensuring shared planning and agreement for the content of the public response.

RxStat participants and leadership should work together to identify the types of events that trigger the need for coordinated investigations among agencies and to establish shared written protocols for responding to these events. In New York City, three types of events have been identified for instituting a shared protocol for a coordinated inter-agency investigation and public response. These events are:

1. A highly publicized fatality where drug poisoning or accidental overdose is suspected, such as the death of participants in a public event or the reported death of a particular individual in the jurisdiction.
2. A geographic cluster of adverse (fatal or non-fatal) health events over a brief period of time where drug poisoning is suspected.
3. A law enforcement drug seizure, purchase, or investigation where atypical and/or potentially lethal drugs, such as fentanyl, are identified.

Coordinated investigations and responses are enabled by the data-sharing and analytic methods established by RxStat. The relationships built through RxStat can facilitate an efficient, comprehensive process and a timely, unified response to events. A shared plan developed through a coordinated investigation can be particularly important in the context of fast-moving media coverage on highly-visible cases.

V. MOVING FORWARD

1. Movement to strategy

The data provides an essential starting point for an integrated approach to developing responsive policy and interventions. The common language that develops during RxStat helps participants to begin thinking about pragmatic strategies for addressing problems identified through the data.

> "To the credit of various partners, they want actionable things to do, so it was the absolute correct strategy to come together around the data, but then who is actionable for those data items, how it bumps up into different issues around silos and leadership…"
>
> *—PUBLIC HEALTH REPRESENTATIVE*

This juncture, moving from problem to strategy, represents the next hurdle for the initiative, and will evolve with the convening of a separate, intervention-focused group of representatives from the jurisdiction.

Moving from the unified, data-driven foundation of RxStat to actionable, measurable strategies is feasible. A few intervention strategies have already been implemented from the RxStat findings in New York City, including:

- Opioid prescribing guidelines for emergency departments in public hospitals
- Overdose intervention training and naloxone prescribing (opioid antidote) for police, as first responders
- Public service announcements on opioid overdose risk
- Public health detailing campaign to prescribers in Staten Island

2. Expand to all drugs

As the initiative progresses, the use of drugs other than prescription opioids have become part of RxStat discussions. These include recent increases in heroin-related deaths, the role of benzodiazepines in opioid-related deaths, and the expanding recreational use of emergent drugs, among other issues. In fact, the health and social problems associated with prescription opioid misuse, such as accidental overdose death, almost always involve other psychoactive substances.

In interviews for the development of this manual, many participants suggested the RxStat initiative should explicitly expand its approach to include all other psychoactive drugs, even

perhaps including alcohol. This preference reflects a natural progression for the work, as it transitions from establishing real-time surveillance of drug-related indicators to developing and implementing strategies to address the drug-related problems RxStat identifies.

Expanding the initiative to include all drugs is simplified by the fact that indicators capturing this information are already in place for RxStat, such as overdose mortality, drug-related hospitalizations, and drug-related arrests.

3. Expand participation

To date, the work of New York City's RxStat has relied on the participation and cooperation of governmental actors, including leadership from jurisdiction-level agencies and representatives from state and federal agencies. This arrangement has enabled data gathering, sharing, and analyzing from among the agencies' administrative datasets to compile a real-time drug-related surveillance system. Now the initiative is reaching its next stage: identifying and implementing actionable strategies to respond to findings in the data.

In this second stage, new agencies or actors may need to be incorporated, and new structures for communication and planning may be needed. These changes will be important to guarantee the continued evolution of the work towards achieving its goal: reducing prescription opioid misuse and problem drug use in the jurisdiction.

a. Non-governmental actors

Governmental agencies do play some role in the implementation of intervention strategies through contracting with non-governmental actors or in their own work as service providers. However, non-governmental actors are also centrally involved, whether as service providers in particular communities, or as advocates for affected groups. Many groups are dually involved in some fashion, providing services in a community-based or institutional context and also participating in coalitions or professional associations to represent, advocate for, or promote policies and practices related to their work.

In its next stage of development, the initiative could benefit from incorporating non-governmental actors into the discussion. These groups could serve a threefold purpose: to report emergent drug problems they observe in their work, to assist with the identification and implementation of intervention strategies, and to offer direction for potential policy strategies to improve health and social outcomes.

b. Legislative actors

Legislative actors could also prove important for furthering the work of the initiative. As elected representatives for the people of their respective districts, they would benefit from learning about findings in the data and about problems of drug use in general. In addition, they could help develop and support the passage of legislation to improve systems, policies, and interventions addressing the health and social problems related to problem drug use in the jurisdiction.

VI. IMPLEMENTATION CHECKLIST

Are you ready to implement an RxStat initiative in your jurisdiction? Review the key elements and their components.

_____ Local champion(s) to initiate the process

_____ Foundational discussions with the local public health agency

_____ Foundational discussions with the local law enforcement agency

_____ Mayoral or county executive prepared to establish the initiative

_____ Identify and engage other public health actors for participation

_____ Identify and engage other public safety actors for participation

_____ Identify and invite relevant state and federal agencies for participation

_____ Prepare an agency home for RxStat data analysis and project management

_____ Identify datasets to initiate RxStat and ensure data use agreements are in place

_____ Enumerate data analyst staffing needs and unmet cost, if any

_____ Identify potential funding sources for unmet staffing costs

_____ Develop and agree upon responsive meeting structure and frequency

_____ Consider which drugs will be included

_____ Consider how and to whom findings will be disseminated

SECTION TWO – DATASETS

OVERVIEW

Data is the core focus and content of RxStat. It is the principal work of the initiative: sharing, preparation, analysis, and presentation of drug-related indicators.

Most of the datasets included in RxStat are generated for administrative purposes by the government agencies who own them. The fact that data are not produced for the specific or sole purpose of tracking and monitoring patterns associated with prescription opioid or other drug misuse has important implications for the initiative. The work of RxStat involves considerable preparation of the datasets before any analysis is possible. In some cases, this process is quite extensive and time intensive. This section of the manual is designed to assist analysts working with these datasets to isolate and present drug-related information from standard administrative datasets.

RxStat's reliance on administrative datasets permits its replication in other jurisdictions, because these data are standardized. Each of the datasets included in RxStat is produced in a similar format at the county or state level throughout the country. This section is structured to provide suggestions and direction for accessing similar datasets in other jurisdictions and for anticipating issues involved in this process.

In the following pages, each RxStat dataset is presented and described. The sources are presented in a hierarchical fashion to reflect the relative importance of each drug-related indicator in a public health framework. The mortality dataset is discussed first, followed by datasets assessing morbidity, and completed with datasets reflecting different aspects of drug use prevalence (i.e., treatment admissions, jail-based health intakes, arraignments, etc.).

The information is presented in a table format and includes considerations for working with each dataset, including: data ownership, access, drugs included, how content is produced, the data request for RxStat, potential lag-time in the data, caveats regarding the particular dataset, data preparation, and the analysis plan for RxStat. Where possible, case selection code and definitions are also provided to assist analysts working directly with these data. Administrative datasets managed by public health agencies are presented first, followed by administrative datasets managed by public safety agencies. The availability and utility of survey data for incorporation into RxStat is briefly discussed in the final chapter of this section.

I. PUBLIC HEALTH ADMINISTRATIVE DATASETS

a. Accidental overdose deaths

NAME	Unintentional (accidental) drug poisoning (overdose) deaths.
AGENCY OWNER	Health department vital statistics office and local medical examiner's office.
ACCESS	Vital statistics records are maintained by the state health department, which receives case reports of overdose deaths from the county medical examiner's or coroner's offices. In smaller jurisdictions, it may be easier to go directly to the medical examiner's or coroner's offices to select the case files of interest and gather information. Due to the higher volume of cases, larger jurisdictions should initiate case-finding with the vital statistics office.
DRUGS INCLUDED	All poisoning deaths in the jurisdiction.
HOW CONTENT IS PRODUCED	Premature deaths or those of unspecified or unnatural cause are investigated by the jurisdiction medical examiner's or coroner's office, including toxicology analyses, the setting of death, and any related information which can be collected through investigation. Based on findings, the medical examiner or coroner assigns the cause and manner of death, and files a case report with the office of vital statistics in the state health department. Here, the case is coded by a nosologist, and a final case record is filed with the vital statistics office.
DATA REQUEST FOR RXSTAT	From the vital statistics office, request all cases with drug-related cause of mortality. See Case Selection Code section below for detailed definition using ICD-10 codes and a case selection protocol. Alternately, in a smaller jurisdiction, request all unintentional or accidental cases from the medical examiner's or coroner's office.
POTENTIAL LAG-TIME	Minimum 4-6 weeks due to toxicology testing and confirmation, and maximum 1.5 years, as vital statistics reports are generally published annually.

DATA NOTES AND CAVEATS	a. The protocol for case selection described here was developed in NYC and provides an exhaustive, specific approach for confirming the identification of all possible unintentional drug poisoning cases, as labeled. Other jurisdictions have adopted different approaches, including reporting on all poisoning cases, regardless of intent, and reporting specific drug involvement in cases based upon vital statistics record reports alone, rather than from toxicology reports examined in case file review. b. In NYC, specific standards have been established for labeling information abstracted from toxicology reports during the case file review. All cases with "morphine" should list "heroin" as a case-involved drug, and all cases with "ethylbenzoylecognine" should list both "cocaine" and "alcohol" as case-involved drugs. Moreover, wherever "alcohol" is found in a drug-involved case, it should be reported and listed as a drug in that case.
DATA PREPARATION	From the final set of cases selected, abstract the following information for each case: decedent sex, age at death, race/ethnicity, zip code of residence, zip code of death, setting of death, drugs involved.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Age, sex, race/ethnicity distribution by neighborhood of residence, by drug type involved, by drug type combinations involved. Neighborhood of residence by drug type involved, by drug type combinations involved.

Case selection code

Definition: Unintentional (or accidental) drug poisoning deaths – Using vital statistics records*

*Note: Using multiple cause cases, in addition to underlying cause cases, provides the most comprehensive approach for using vital statistics records to identify unintentional drug poisoning deaths. It is reasonable to restrict this analysis to underlying cause cases only, thus eliminating step 5 below.

1. Select all poisoning cases for the period of interest.
   a. Select the following codes, both underlying and multiple cause (X40-X49; X60-X69; X85-X90; Y10-Y19; U01{.6-.7}; F11-F16; F18-F19; R99)
2. Restrict "manner" to accident.
3. Restrict age of decedent to be 15-84 years.
4. Break out cases that have underlying cause of X40-X44, F11-F16, F18-F19 (excluding F codes where the third digit is .2 or .6), R99.

5. Using file of cases that do not have X40-X44, F11-F16, F18-F19 (excluding F codes where the third digit is .2 or .6), R99 as an underlying code.
    a. Break out those cases that have X40-X44, R99 in the multiple cause file with any underlying code.
    b. Review cases that have an X40-X44, R99 in the multiple cause field, with any other underlying code. These cases should be reviewed manually by reviewing the literal cause of death in both Part 1 and Part 2. Cases should be excluded for the following reasons:
        i. Drug is mentioned in Part 2 of the death certificate only
        ii. Death is due to a non-drug poisoning such as carbon monoxide
        iii. Death is due to salicylate or acetaminophen poisoning
        iv. Record not confirmed at the OCME
        v. Death is due to a physical cause such as:
            - Drowning
            - Blunt force trauma
            - Asphyxia
            - Hypothermia/Hyperthermia
6. The final case file should include all cases with an underlying cause of X40-X44, F11-F16, F18-F19 (excluding F codes where the third digit is .2 or .6), R99 and any cases that were found and kept in step 5) above.

b. Hospitalizations with drug-related diagnoses

NAME	SPARCS (Statewide Planning And Research Cooperative System). See data notes below for further information.
AGENCY OWNER	State Department of Health (SDOH) or state licensing authority for healthcare facilities.
ACCESS	From SDOH, through formal arrangement, e.g., IRB, data use agreement.
DRUGS INCLUDED	All ICD-9 codes for any drug-related discharge (includes drug-specific codes).
HOW CONTENT IS PRODUCED	All state-licensed hospital and ambulatory care clinic facilities report patient discharge data to the licensing authority, e.g., SDOH. Each discharge is reported as a unique record; patients can have multiple records, if they have multiple discharges within a given time period. Discharge records include diagnostic codes (ICD-9) for principal, secondary, and injury diagnoses.
DATA REQUEST FOR RXSTAT	RxStat requests all unique discharge records generated by licensed healthcare facilities within the jurisdiction during a period of interest (usually by calendar year), for all drug-related diagnoses, excluding injury diagnoses (E-codes) of suicide, homicide, or undetermined intent. Discharge records are anonymized but assigned unique identifiers for each patient. Variables in the discharge record include: patient unique identifier, gender, race/ethnicity, age at time of admission, and zip code of residence; healthcare facility location; if ICD-9 diagnosis in case selection list, then included in definition for any drug-related diagnosis (for detail, see Case Selection Code section below).
POTENTIAL LAG-TIME	One year, due to reporting lags from facilities (up to three months) and subsequent data-cleaning at SDOH.
DATA NOTES AND CAVEATS	a. In other states, this dataset is known by different names, including State Emergency Department Databases, State Inpatient Databases. b. This dataset excludes federally-managed healthcare facilities operating in the state, e.g., Veterans Administration facilities. c. The Healthcare Cost and Utilization Project (HCUP) provides access to health statistics and information on hospital inpatient and emergency department utilization.

DATA PREPARATION	Use patient zip code of residence to categorize records by neighborhood, borough, state, and other. Define counts of unique patients by first hospitalization in the period of interest. Aggregate frequency and distribution of records, N (%). Calculate age-adjusted rates: (i) intercensal jurisdiction population estimates as denominators for the year of interest, (ii) age-adjust to US standard census 2000 weights.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Number of hospitalizations overall and by drug type. Number of patients hospitalized by demographics (gender, race/ethnicity, age, borough of residence/hospital, neighborhood poverty level, UHF42). Diagnoses: • Principal, secondary • Drug psychoses (292.x), dependence (304.x), abuse (305.x) • Poisoning • Co-morbidities based on HCUP diagnostic groupings Procedures. Average length of stay.

Case selection code

Definition: Any drug-related discharge –

if diagnosis in ('292.xx','304.xx','965.xx','967.xx','969.xx','970.xx','305.2x','305.3x','305.4x', '305.5x','305.6x','305.7x','305.8x','305.9x','357.6','648.3x','655.5x','779.5', '968.0','968.5',760.72','760.73','760.75','970.81','E850.x','E851','E852.x', 'E853.x','E854.x','E855.1','E855.2','E935.0','E935.1','E935.2','E950.0', 'E950.1','E950.2','E950.3','E950.4','E962.0','E980.0','E980.1','E980.2', 'E980.3','E980.4')

then ICD-9='Any drug-related diagnosis';

Definition: Opioid-related discharge –

if diagnosis in ('304.0x', '305.5x', '304.7x', '965.0x', 'E850.0', 'E850.1', 'E850.2', 'E935.0', 'E935.1', 'E935.2')

then ICD-9='Any opioid related diagnosis';

c. Poison Control Center calls

NAME	Poison Control Center calls.
AGENCY OWNER	Poison Control Center (PCC) for jurisdiction, region, or state.
ACCESS	From PCC, direct system access via electronic portal through formal arrangement, i.e., data use agreement.
DRUGS INCLUDED	All controlled substance-related calls.
HOW CONTENT IS PRODUCED	Calls are received by PCC from a variety of sources, most frequently from clinicians in health care facilities. Information is logged and completed in a centralized call database by PCC staff in near real-time, per shift, as the reason for the call is handled.
DATA REQUEST FOR RXSTAT	RxStat has direct, real-time system access via electronic portal to all variables in the PCC database, including categories detailing patient information, substance in question, treatment information, outcome information, and caller information.
POTENTIAL LAG-TIME	Real-time, within 24 hours of PCC receipt of the call.
DATA NOTES AND CAVEATS	a. Due to low counts for other controlled substance-related calls in NYC, only opioid analgesic-related calls are presented for inclusion in RxStat. b. Patient zip code of residence is provided in only 15% of NYC call records; analysis is not possible for geographic distribution of patients' residence.
DATA PREPARATION	Patient information includes: call intake date, sex, age, zip code. Substance in question includes: substance category, substance description, caller verbatim, exposure type, exposure site (ingestion, other route, unknown route), acute or chronic. Treatment information includes: management, disposition (if treated in health care facility), initial health care facility, final health care facility. Outcome information includes: medical outcome, estimated effects duration. Caller information includes: caller relationship, caller county, caller state, caller zip code.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Volume (N) of opioid analgesic-related calls received per calendar quarter, in comparison with volume (N) received in previous year same calendar quarter.

d. Emergency department admissions for suspected overdose events

NAME	Emergency Department (ED) syndromic data.
AGENCY OWNER	Hospital emergency departments (ED), who may upload to local health departments in larger cities for analysis purposes (see data notes below).
ACCESS	Internal database at city health department, direct system access via electronic portal through formal arrangement, such as a data use agreement.
DRUGS INCLUDED	All ED admissions noting overdose-related chief complaints or diagnoses.
HOW CONTENT IS PRODUCED	ED admissions are recorded by ED staff in real-time at the point of service in the ED electronic health record. Each record includes text describing the patient's chief complaint, sometimes supplemented or substituted with an ICD-9 diagnosis code. (In NYC, ED admission records are uploaded to the city health department via electronic portal every 12 hours.)
DATA REQUEST FOR RXSTAT	RxStat has direct, real-time system access via electronic portal to all variables in the ED syndromic database, including date of visit, time of visit, chief complaint, hospital, patient sex, patient zip code of residence, patient age, mode of arrival, and disposition. See Case Selection Code section below for coding instructions to identify all chief complaints defined as "overdose."
POTENTIAL LAG-TIME	Real-time, within 24 hours of ED visit.
DATA NOTES AND CAVEATS	a. Real-time uploads from EDs to local health departments are usually arranged to conduct public health surveillance of communicable disease outbreaks and suspected bioterrorism events. Tracking suspected drug overdose events represents a novel use of syndromic data. b. If the jurisdiction is small or the local health department does not receive hospital ED uploads, alternately, RxStat analysts could arrange daily reviews of local ED data with ED or hospital leadership.
DATA PREPARATION	Data are analyzed by date, ED, patient zip code of residence, neighborhood of residence, and neighborhood of hospital. Statistical tests are performed to identify any increase above what would be expected (level of significance, 5%). These analyses are used for internal purposes only.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Volume of "overdose" cases per calendar quarter, in comparison with previous year same calendar quarter.

Case selection code

Definition: Overdose –

```
OD=Prxmatch("/ OD|OD | O\.D\.|O\.D\. | O[[:punct:]]D|^OD|OVERDO|OVER DOSE|OVER D|
DRUG O.|O. DOSE|EXTRA DOSE|OPVER DOSE|OVER.DO.E|TOO MUCH DRUG|TOO MANY DRUG
|OUDOSE|D.O.D /", CC) >0;

        **OD Exclude;
        If OD GE 1 Then
        Exclude1=Prxmatch("/PERIOD|LOOD|BODY|CODE|ODONTAL|GOD|EPISOD|NODULE|
TODAY|MODERATE|PRODUCTIVE|DISLODGED|ODOR|C[[:punct:]]O D|HEMODIALYSIS|PROD|
NODES|SODIUM|O D/", CC) >0;
        Else Exclude1=.;

        If OD GE 1 AND Exclude1=0 Then
        Exclude2=Prxmatch("/ODOUR|POD|EXTRNOD|BOOD|DISCHARGE|OPPOSITIONAL|NOD
|ROD|BLLOD|BLOD|PARANIOD|TOD|ODD BEHAVIOR|PROSTATE|THYRIOD|SUGAR|BOD
|STERIOD|TA[LG][LG]IA|ALGIA|.OOD|HEM[MO]|FIBRIOD|ODON/", CC) >0;
        Else Exclude2=.;

        If Exclude1 > 0 Then Exclude=1;
        Else if Exclude2 >0 Then Exclude=1;
        Else Exclude=.;

        If OD > 0 And Exclude NE 1 Then Overdose=1;
        Else Overdose=0;

        Drop OD Exclude Exclude1 Exclude2;
```

e. Ambulance calls for suspected overdose events

NAME	Emergency Medical Services (EMS) ambulance calls.
AGENCY OWNER	Fire department or first responder agency responsible for oversight of all EMS services in the jurisdiction.
ACCESS	Data prepared for RxStat by first responder agency owner.
DRUGS INCLUDED	All ambulance calls responding to suspected drug overdose incidents.
HOW CONTENT IS PRODUCED	Information on EMS calls is recorded electronically for all agency-managed EMS calls. Each call includes zip code of dispatch and clinical indicators such as vital signs and prior medical history.
DATA REQUEST FOR RXSTAT	All calls where naloxone was administered.
POTENTIAL LAG-TIME	EMS data is collected in real-time. For the purposes of RxStat, it is prepared and provided by the agency owner on a monthly basis.
DATA NOTES AND CAVEATS	Some cases are not overdoses; naloxone was administered as a precautionary measure, but it was subsequently determined the case was not an overdose.
DATA PREPARATION	Clinical data from the call is examined to remove calls that meet exclusion criteria (in development).
ANALYSIS PLAN FOR RXSTAT	Spatial distribution of probable non-fatal overdoses in comparison with the spatial distribution of fatal overdoses.

f. Substance use disorder treatment admissions

NAME	Substance use disorder treatment admissions dataset. See data notes and caveats for detail.
AGENCY OWNER	Single state agency (SSA) reporting to federal Substance Abuse and Mental Health Services Administration (SAMHSA).
ACCESS	From SSA, as data tables prepared by SSA for RxStat.
DRUGS INCLUDED	All substances, reported by drug class or specific drug type (where prevalence of specific drug use is dominant).
HOW CONTENT IS PRODUCED	All licensed programs report patient-level treatment admissions data to the SSA via electronic reporting system.
DATA REQUEST FOR RXSTAT	RxStat receives data tables of aggregated data, including: participant demographics and socio-economic status; self-reported drug use (type, frequency, route of administration); referral source and detail.
POTENTIAL LAG-TIME	Estimated lag time of 6 months after the treatment event. Annual reports are available from SAMHSA TEDS with a lag-time of one calendar year.
DATA NOTES AND CAVEATS	a. SSA are required to report all treatment admissions data to SAMHSA on a routine basis. SAMHSA compiles these data as the Treatment Episode Data Set (TEDS) and presents information by state, reporting aggregate characteristics of treatment admissions per calendar year. For details, see website: http://wwwdasis.samhsa.gov/webt/information.htm
DATA PREPARATION	Sort records to identify those for the jurisdiction of residence for the time period of interest. (In NYC, the jurisdiction level used for sorting and preparing this dataset is the county, or borough.)
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Opioid and opioid-type misuse admissions, overall (N,%), by borough, by age, by route of administration, by referral source. Other drug class and type misuse admissions occurring with considerable frequency (N, %), by borough, by age, by route of administration, by referral source.

g. Jail health services intakes

NAME	Jail health services intake dataset.
AGENCY OWNER	Local health department or provider contracted to deliver healthcare services.
ACCESS	From provider, direct system access via electronic portal to electronic health record, arranged by data use agreement.
DRUGS INCLUDED	All drug use self-reported by prisoners at intake, and identified in prisoner urine drug screening at intake.
HOW CONTENT IS PRODUCED	Within 24 hours of admission to the jail, new prisoners undergo a full physical and mental health examination. The jail healthcare provider uses an electronic health record to manage patient information.
DATA REQUEST FOR RXSTAT	Via electronic portal, RxStat has access to specific patient-level variables in the electronic health record, including: gender, race, ethnicity, zip code of residence, age on intake, education level; self-reported drug use (type, frequency, quantity); self-reported mental health history; urine drug screen results, all drugs identified.
POTENTIAL LAG-TIME	Lag-time is dependent on whether there is an electronic health record system in place. With an electronic health record system, data is available in real-time via the electronic portal.
DATA NOTES AND CAVEATS	a. All jurisdictions are required to provide adequate medical care to prisoners. b. In larger jurisdictions, the local health department may deliver or oversee healthcare services in the jail, but in most jurisdictions, care is delivered via agreement with a local healthcare provider.
DATA PREPARATION	Count of new admissions during a time period of interest with reported or identified drug use, by drug type and demographics. Assign zip code of residence to neighborhood and borough.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Opioid misuse among new admissions, overall (N, %), by neighborhood and borough, by age. Other drug misuse among new admissions (N, %), by drug type.

h. Dispensed prescriptions for controlled substances

NAME	Prescription Monitoring Program (PMP) or Prescription Drug Monitoring Program (PDMP).
AGENCY OWNER	State agency authorized by law to manage the program.
ACCESS	Direct electronic access, negotiated through formal arrangement with state agency, such as data use agreement.
DRUGS INCLUDED	All controlled substances prescribed for medical use in that state.
HOW CONTENT IS PRODUCED	Standards and methods vary somewhat from state to state, and are established in legislation. In all states with PMP, pharmacists filling a controlled substance prescription are required to submit related patient and drug information to the PMP. In addition, in some of these states, physicians prescribing a controlled substance must also submit related patient and drug information to the PMP office. The PMP office maintains these data as case records of each prescription event. A new record is produced for each prescription; patients can have multiple records.
DATA REQUEST FOR RXSTAT	From the PMP office, direct system access is provided for patients, providers, and pharmacies with a NYC zip code. The dataset includes four levels of data: prescription, patient, prescriber, and pharmacy.
POTENTIAL LAG-TIME	Lag-time is dependent on the PMP reporting system in place in the state. Some PMP offices maintain an on-line, real-time, state-wide electronic reporting system for providers, which should ensure complete data within one week (maximum) of the prescription event, if RxStat negotiates an agreement for direct access to the system. Many PMP offices maintain an internal tracking system, receiving, cleaning, and entering data from providers on a monthly basis, with an allowable lag-time of up to two weeks following the close of the reporting month. For datasets from these states, lag-time for RxStat analysis could extend up to three months, given time for data cleaning and report preparation within the PMP office.
DATA NOTES AND CAVEATS	Some states have not implemented a PMP. For a recent list and map of the status of states' PMP programs, please see: http://www.namsdl.org/library/1E4808C8-1372-636C-DD0293F829471A7E

DATA PREPARATION	1. Methods for data cleaning: i) Location (residence, prescriber location, pharmacy location) • Use 3 digit zip code to create borough, state, and other. • Report borough level information. • For patient and prescriber calculate the most frequent location for the person in the period of interest. ii) Patient age • Age is at prescription refill. • Calculate the average age in the period of interest to obtain patient age in the period of interest. iii) Reassign "oxymorphone" per detail provided in Case Selection Code section below. iv) Apply short-acting and long-acting classifications provided in Case Selection Code section below. v) Apply "Schedule II" definition, provided in Case Selection Code section below. vi) Apply exclusions, provided in Case Selection Code section below. 2. Calculate age-adjusted rates • Use population estimates as denominators for the year of interest. • Age-adjust to US Standard Census 2000 weights
ANALYSIS PLAN FOR RXSTAT	Drug types include: Codeine, Fentanyl, Hydrocodone, Hydromorphone, Meperidine, Methadone, Oxycodone, Oxymorphone, and Pentazocine. RxStat indicators: • Number of prescriptions filled overall and by type • Number of patients filling prescriptions by demographics (age, gender, residence) • Number of prescribers • Number of pharmacies • Median day supply of prescriptions • Morphine equivalent dose (MED) of prescriptions • Number and rate of high dose (morphine equivalent dose ≥ 100) prescriptions filled

Case selection code

Definition: Oxymorphone –

if ndc number in ('16590060930','16590060960','16590060990','16590074730',
16590074756','16590074760','16590074790','16590076730','16590076756',
16590076760','16590076790','21695094860','21695094960','60760061760',
63481052270','63481052275','63481055370','63481055375','63481057170',
63481057175','63481061270','63481061370','63481061770','63481061775',
63481062410','63481067470','63481067475','63481069370','63481069375',
63481090770','63481090775','63629417301','63629417302','63629417303',
63629417304','63629417401','63629417402','63629417403','63629417701',
63629417702','63629417703') then ndc_acronym='OXYM';

Definition: Short-acting and Long-acting drug classifications –

- Merging by NDC number, the NDC file available from CDC Injury Center (see XXX)
- For any prescription with missing short acting or long acting classification, assign according to drug type for drugs that are only short acting in form or long acting in form.
- Apply MED calculations
- Cannot calculate MED with prescriptions missing information on strength, quantity dispensed, day supply, or Morphine Milligram Equivalent conversion factor.
- Check data for any missing information and apply formula to those without missing information.
- Exclude missing day supply, day supply = 999.
- Formula: dailydose = (strength*quantity_dispensed)/days_supply;
- MED = dailydose*MME_CONVERSION_FACTOR

Definition: Schedule II controlled substances –

('FENT', 'HYDM', 'MEPE', 'METD', 'MORP','OXYC','HYDC', 'OXYM')

Exclusions –

- Exclude institutions: dea_busncode ne 'B'
- Exclude veterinarians: dea_profcode not in ('74', '75') and lic_specode not='500'
- Exclude missing patient number as these patients cannot be uniquely identified
- Exclude missing prescriber number as these providers cannot be uniquely identified

II. PUBLIC SAFETY ADMINISTRATIVE DATASETS

a. Pharmacy orders for prescription opioid medication stock

NAME	Automation of Reports and Consolidated Orders Systems (ARCOS).
AGENCY OWNER	Drug Enforcement Administration (DEA).
ACCESS	A law enforcement agency must make the request to the DEA for ARCOS data. In NYC, NY/NJ HIDTA obtained approval from DEA headquarters via a request for a data report submitted by the local DEA office (which participates in RxStat).
DRUGS INCLUDED	All Schedules I and II materials and Schedule III narcotic and gamma-hydroxybutyric acid (GHB) materials.
HOW CONTENT IS PRODUCED	Reports are filed to DEA at three levels: (1) by manufacturers at the point of a logged order, (2) by a regional distributor to report what is in inventory and what is being ordered, and (3) by a local pharmacy to report what is in inventory and what is being ordered. Report to ARCOS is generated at the point of transaction, and reflects orders placed and inventory in stock for each drug (by NDC# and dosage units).
DATA REQUEST FOR RXSTAT	RxStat receives data from DEA on a calendar quarterly basis. Data reports orders only from pharmacies in the jurisdiction. RxStat does not receive data from DEA on what stock is in inventory at local pharmacies. Data is provided on all Schedule II and III controlled substances ordered by pharmacies at the zip code level. The variables included are: NDC number, NDC trade name, drug type, package size, total dosage units, and grams of controlled substance.
POTENTIAL LAG-TIME	Minimum one calendar quarter lag, up to two calendar quarters lag.
DATA NOTES AND CAVEATS	a. Law enforcement may be able to obtain access to examine specific pharmacies with consistent high-volume orders for unexplained suspicious activity. b. RxStat could also request inventory reports alongside order reports, to develop a fuller picture for local availability of controlled substances in pharmacies.

DATA PREPARATION	All data is anonymized, stripped of identifying name or location characteristics other than zip code. Data is prepared as follows: Merge ARCOS file with the NDC product codes, NDC package codes, and CDC MME conversion worksheet. Identify any NDC codes not in the files above and manually add in the missing data. Create a master strength field for analysis. Create a pill variable to exclude all liquids, powders, suppositories, patches, sprays, solutions, etc. Using the NDC codes and CDC files, categorize all opioid analgesics into specific drug types (morphine, hydrocodone, oxycodone, etc.). Calculate the morphine milligram equivalent for each type of opioid analgesic. Create a borough variable from pharmacy zip code.
ANALYSIS PLAN FOR RXSTAT	Drug types include: All Schedule II and III substances, including: Codeine, Fentanyl, Hydrocodone, Hydromorphone, Meperidine, Methadone, Oxycodone, Oxymorphone, and Pentazocine. RxStat indicators: # pills per drug type by borough of pharmacy, per quarter.

b. Drug-related prosecutions

NAME	Drug-related prosecutions.
AGENCY OWNER	District Attorney's (DA) Office.
ACCESS	Gained through DA participation.
DRUGS INCLUDED	All prosecutions for narcotic drugs and controlled substances are included. The data captured is based upon prosecution charge, not arrest charge. Of note, in New York State, marijuana-related arrests are classified under a different statute than controlled substances and narcotic drugs. This marijuana statue is not selected during data compilation, but marijuana is included in the data capture if it is present in a case alongside a controlled substance or narcotic drug.
HOW CONTENT IS PRODUCED	Information on a DA Office's system serves as the dataset for analysis, and includes both information the DA Office receives from the Police Department and information the DA Office produces. The "complaint language" is written by an Assistant District Attorney assigned to the case in the intake bureau, and is included in a legal document where the ADA sets forth the grounds for the criminal charges. This "complaint language" is used to capture and identify drug type(s) involved in a specific prosecution.
DATA REQUEST FOR RXSTAT	RxStat receives data from the DA Offices as it is produced and prepared for monthly working group meetings. Data is organized per prosecutions by the DA Office for narcotic drugs and controlled substances (not including marijuana unless it is present in a prosecution involving narcotic drugs and/ or controlled substances). Data elements per prosecution include: (1) demographics - defendant's age, gender, race, zip code of residence, residence precinct; (2) location - arresting precinct, address of arrest; (3) charges – top screening drug charge, top screening sale charge, top screening possession charge; (4) drugs involved.
POTENTIAL LAG-TIME	Up to one month.

DATA NOTES AND CAVEATS	a. Reflects the practice and approach of prosecutors' offices in New York City, which may differ considerably from other jurisdictions. b. Includes only cases arraigned on narcotic drugs and controlled substances charges; does not include arrests where these charges were subsequently dropped. c. The data includes number of prosecutions, and number of instances of a drug. Oftentimes cases involve more than one drug, as such the "instances" total for a given time period will far outnumber the "prosecutions".
DATA PREPARATION	SQL code is used to draw information from the DA Office's system. The main functions of the code are to isolate the drug related prosecutions out of total prosecutions (and within a certain time frame), pull relevant information about the case (ie, about the defendant, charges, and location of arrest), and indicate which drug(s) were involved. Drug related prosecutions are isolated by using the specific penal charges for narcotic drugs and controlled substances. To identify which drugs are involved, the complaint language is searched for key drug terms, including common misspellings of these terms. Records (prosecutions) are then labeled as including or absent the identified drug type(s). Code output is transferred to a relational table (e.g., Excel). Records which have not been classified with a drug type through this process are manually coded by individually looking up the case on the DA Office's system and attempting to ascertain the drugs involved. If new misspellings for a particular narcotic drug or controlled substance are thereby discovered these are recorded and utilized in future searches to reduce the need for hand recoding. The cases are only hand recoded if no drug is classified, so there is a margin of error as in a case where there are controlled substances or narcotic drugs that are misspelled but not with a known misspelling and other controlled substances or narcotic drugs are also present and spelled correctly. In such cases, the DA Office will not know to hand recode those cases and instances of drugs will be missed. For sending the data out of the DA's office, records are anonymized and de-identified, by removing docket information, screening date and outcome, bureau of case, case status, sentence type, individual identifiers of defendant(e.g., name, arrest ID, date of birth, defendant address), and the text of the complaint language.

ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Narcotic drug and controlled substance prosecutions by drug type, as a proportion of all narcotic drug and controlled substance prosecutions, during the period of interest by borough. If the prosecutions data is displayed visually, one must take caution to specify if the data displayed is by prosecution or by instance. This is due to the fact that many cases involve more than one drug type hence the instances will outnumber the number of prosecutions. Most commonly, RxStat utilizes the graphs or charts that reflect the number of instances of each drug type out of total number of incidences of all drugs. Additionally, (where relevant) prosecutions by age, neighborhood, felonies versus misdemeanors, location of residence as compared to location of arrest, etc. can be analyzed.

Case selection code varies by prosecutor's office.

c. Pharmacy/clinic/doctor's office burglaries and robberies

NAME	Burglaries and robberies at pharmacies and clinics/doctor's offices where the intent is to obtain controlled prescription drugs.
AGENCY OWNER	Police department (PD).
ACCESS	Provided through PD participation in RxStat.
DRUGS INCLUDED	Any controlled substance reported as stolen or missing as a result of the robbery or burglary. See Data notes below.
HOW CONTENT IS PRODUCED	Any reported burglary or robbery of a pharmacy or clinic or doctor's office location (as recorded by PD).
DATA REQUEST FOR RXSTAT	RxStat receives data from PD as it is produced and prepared for monthly work group meetings. Data is organized per event. Data elements per event include: (1) date; (2) type of location – pharmacy or clinic/doctor's office; (3) geographic location; (4) mode of entry; (5) drugs – substances taken (types, strength); # pills taken (if available); (6) arrest made.
POTENTIAL LAG-TIME	Up to one month.
DATA NOTES AND CAVEATS	a. Definitions – "burglary" represents entry to premises when no one is there, and "robbery" represents on-premises demand for medication from an employee. b. Definitions (New York City) – "attempted burglary" represents an attempt to enter premises without success. If a perpetrator successfully enters the premises, even if not successful in obtaining controlled prescription drugs, the event is not indicated as attempted. c. In the events where nothing was stolen, it is presumed that the intent was to access controlled substance medications (and thus included in the counts), unless the intent was clearly to obtain other items such as cash or cigarettes.
DATA PREPARATION	Data are quantified and detailed by PD.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Number of burglaries and robberies of pharmacies and clinics/doctor's offices in each county during the period of interest. Number of pills taken from burglaries and robberies during specific time period and location, reported by drug type (if available).

d. Loss or theft of controlled substance medications

NAME	DEA-106 loss/theft report.
AGENCY OWNER	Drug Enforcement Administration (DEA).
ACCESS	A law enforcement agency must make the request to the DEA for DEA-106 data. In NYC, NY/NJ HIDTA requested the data report from the local DEA office (which participates in RxStat).
DRUGS INCLUDED	Any prescribed medication defined as a controlled substance.
HOW CONTENT IS PRODUCED	Report is filed to DEA by any entity with a DEA #, including pharmacy, distributor, and manufacturer, within 24 hours of the time of an event involving the loss or theft of controlled prescription medication.
DATA REQUEST FOR RXSTAT	RxStat receives data from DEA on a calendar quarterly basis for losses reported by pharmacies, manufacturers, or distributors. Data reports on location of pharmacy, manufacturer, or distributor, drug type, medication dosage, and quantity missing.
POTENTIAL LAG-TIME	Up to one month.
DATA NOTES AND CAVEATS	a. Reports on losses incurred which are categorized as: armed robbery, customer theft, employee pilferage, lost in transit, night break-in, or other.
DATA PREPARATION	N/A
ANALYSIS PLAN FOR RXSTAT	Drug types are any controlled substance, and include: Codeine, Fentanyl, Hydrocodone, Hydromorphone, Meperidine, Methadone, Oxycodone, Oxymorphone, and Pentazocine. RxStat indicators: Number of incidents by incident type, by county. Number of pills by drug type or incident type, by county.

e. Medicaid coverage of local residents for prescribed controlled substance medications

NAME	Medicaid-covered prescriptions to residents for controlled substance medications.
AGENCY OWNER	Local department of social services (DSS) or human services.
ACCESS	Provided by local DSS office participating in RxStat.
DRUGS INCLUDED	Any prescribed medication defined as a controlled substance.
HOW CONTENT IS PRODUCED	Report is produced by DSS, based on prescriptions covered by Medicaid to local residents for controlled substance medications.
DATA REQUEST FOR RXSTAT	RxStat receives data produced and prepared by DSS on a quarterly basis. Data is presented at three levels: 1. Recipients – per zip code, NDC # and name, average days duration prescription, average recipient age, county, # transactions, # unique recipients, total dosage units per NDC #, average number of refills. 2. Pharmacy providers – per zip code, NDC # and name, total dosage units, average days supply, average # refills, average recipient age, county, # transactions, # unique pharmacies. 3. Clinician prescribers – per zip code, NDC # and name, total dosage units, average days supply, average # refills, average recipient age, county, # transactions, # unique prescribers.
POTENTIAL LAG-TIME	Up to one calendar quarter, based on Medicaid billing cycles and subsequent data cleaning needs.
DATA NOTES AND CAVEATS	1. Captures information on prescriptions filled only. 2. Captures information on prescriptions to Medicaid beneficiaries and which were covered by Medicaid, requiring rate calculations that present this information as a proportion of the total number of Medicaid beneficiaries in that area (eg, per zip code).
DATA PREPARATION	Information is initially prepared by DSS in tables for each level of data, as described above. Group NDC # by drug type (eg, oxycodone) and calculate total dosage units, average number of refills, average duration of prescription – per zip code.
ANALYSIS PLAN FOR RXSTAT	RxStat indicators: Rate of drug type total dosage units per zip code Average # of refills, average duration of prescription, per zip code

III. SURVEY DATA

a. Youth drug use behaviors

NAME	Youth Risk Behavior Surveillance System (YRBSS).
AGENCY OWNER	Centers for Disease Control (CDC) via state health department.
ACCESS	Through CDC online query system, or through specific reports produced by state health department. Information is available at: http://www.cdc.gov/HealthyYouth/yrbs/index.htm?s_cid=tw_cdc16
DRUGS INCLUDED	Marijuana, cocaine, inhalants, heroin, methamphetamine, ecstasy, prescription pain medications (opioids), other prescription drugs (including benzodiazepines).
HOW CONTENT IS PRODUCED	Survey is administered to a representative sample of anonymous public high school students in the state, in the classroom, on a biannual basis. Data is compiled and cleaned by state health department, and submitted to the CDC for analysis and reporting.
DATA REQUEST FOR RXSTAT	Reports on drug type distribution by demographics and geography (where feasible).
POTENTIAL LAG-TIME	Survey is administered biannually; data is available for analysis and reporting 6 months after the calendar year reporting.
DATA NOTES AND CAVEATS	a. YRBS is a state-wide survey. As a result, data is not representative for regions of the state, only for the state as a whole. b. NYC is the only local jurisdiction administering its own YRBS; data is available by borough.
DATA PREPARATION	N/A
ANALYSIS PLAN FOR RXSTAT	For examples see: http://www.cdc.gov/HealthyYouth/yrbs/index.htm?s_cid=tw_cdc16

b. Adult drug use behaviors

NAME	National Survey on Drug Use and Health (NSDUH).
AGENCY OWNER	Substance Abuse and Mental Health Services Administration (SAMHSA).
ACCESS	Through SAMHSA reports produced for state-level data, or individual queries for analyses of large municipalities. For further information see: http://www.samhsa.gov/data/NSDUH.aspx
DRUGS INCLUDED	Marijuana, cocaine, heroin, hallucinogens, inhalants, psychotherapeutics (including sub-categories for pain relievers, tranquilizers, stimulants, sedatives).
HOW CONTENT IS PRODUCED	Survey is administered to a representative sample of adults (age 12 years and older) in the state, in person and anonymously, using computer-assisted survey software to preserve the confidentiality of responses.
DATA REQUEST FOR RXSTAT	Reports on drug type distribution by demographics.
POTENTIAL LAG-TIME	Survey is administered annually; data reports are available up to one year after the calendar year reporting.
DATA NOTES AND CAVEATS	a. Annual NSDUH data is geographically representative at the state level only. b. For large municipalities, it may be possible to achieve sufficient power in the data at the local level by combining multiple years of data.
DATA PREPARATION	N/A
ANALYSIS PLAN FOR RXSTAT	For examples see: http://www.samhsa.gov/data/NSDUH.aspx

c. Arrestee drug use detection

NAME	Arrestee Drug Abuse Monitoring (ADAM) program.
AGENCY OWNER	National Institute of Justice (NIJ).
ACCESS	Through specific information query to NIJ or from report produced; see: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/adam_ii_2012_annual_rpt_final_final.pdf.
DRUGS INCLUDED	Marijuana, cocaine, heroin and other opiates, methamphetamine, other drugs.
HOW CONTENT IS PRODUCED	Survey is administered at selected courts in selected large cities during selected years, to all arrestees who are admitted to that court. Participation is voluntary and involves self-reported drug use data and urinalysis monitoring.
DATA REQUEST FOR RXSTAT	Reports on drug type distribution by demographics.
POTENTIAL LAG-TIME	Survey is administered annually; data is available for analysis and reporting 6 months after the calendar year reporting.
DATA NOTES AND CAVEATS	a. This dataset is not used in RxStat b. In 2012, survey was administered in Atlanta, Chicago, Denver, New York, Sacramento, Washington D.C.
DATA PREPARATION	N/A
ANALYSIS PLAN FOR RXSTAT	N/A

d. Emergency room admissions with drug mentions

NAME	Drug Abuse Warning Network (DAWN)*
AGENCY OWNER	Substance Abuse and Mental Health Services Administration (SAMHSA).
ACCESS	Through information queries to SAMHSA, and from reports produced by the program, see: http://www.samhsa.gov/data/DAWN.aspx
DRUGS INCLUDED	Illicit drugs and prescription drugs.
HOW CONTENT IS PRODUCED	General, non-federal, short-stay hospitals in 12 metropolitan areas were invited to participate. For those hospitals responding to the invitation, a trained reporter was stationed at the institution to conduct retrospective data collection of all emergency department (ED) medical records and note "drug mentions" related to drug abuse or misuse, via a standard abstraction protocol.
DATA REQUEST FOR RXSTAT	Reports on drug type distribution by demographics.
POTENTIAL LAG-TIME	Data abstraction and analysis is conducted annually; data is available for analysis and reporting one year after the calendar year reporting.
DATA NOTES AND CAVEATS	a. This dataset is not used in RxStat b. *Last year of reporting was 2011. Program has since been discontinued
DATA PREPARATION	N/A
ANALYSIS PLAN FOR RXSTAT	N/A

NEW YORK CITY
DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

NY/NJ HIDTA

Appendix S

CLARK COUNTY REGIONAL OPIOID TASK FORCE
ORIENTATION AND TRAINING
SATURDAY, JANUARY 20, 2024
9:00 A.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. **The public is invited to comment.**

MEETING MINUTES

1. Call to Order

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 9:09 a.m.

Committee Members Present:
Melanie Rouse, Chair
Jamie Sorenseon, Vice Chair
Rosa O'Bannon
Meambi Newbern-Johnson
Eboni Washington
Greg Theobald
Brandon Delise
Jessica Johnson
Geoconda Hughes
Brian O'Neal
BachTrinh Dang
Jerry Cade
Dolletta Mitchell
Chelsi Cheatom

Not Present:
Thomas Alfreda

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

There were no comments from the public.

3. Opening Remarks and Oath of Office

Commissioner Marilyn Kirkpatrick welcomed and thanked the members for serving on the Task Force, as well as administered the Oath of Office for all present members as a group.

4. Receive Presentation of Nevada's Open Meeting Law, Nevada Ethics Law, and Robert's Rules of Order. (*For discussion only)*

DA Timothy Allen presented on Open Meeting Law and Nevada Ethics Law. (Presentation is attached.)

Following Dan Giraldo presented on Robert's Rules of Order. (Presentation is attached.)

5. **Introduction to Clark County Regional Opioid Task Force (*For discussion only)***

   Members of the Task Force introduced themselves.

   Joanna Jacob presented on the overview of Task Force member roles and responsibilities. (Presentation is attached.)

6. ***Review and approve 2024 scheduled Task Force meeting dates, times, and location of the Clark County Regional Opioid Task Force. *(For possible action)***

   Joanna Jacob noted proposed scheduled meetings for members to vote to adopt the proposed meeting as presented.

   - **Motion by:** Eboni Washington move to adopt the 2024 scheduled Task Force meeting dates, times, and location. Brian O'Neal second the motion.
   - **Motion PASSED/Unanimous**

7. **Public Comment**

   At this time, Chair Rouse asked if there was anyone wishing to make public comment.

   There were no comments from the public.

8. **Adjournment**

   Meeting was adjourned at 10:39 a.m.

---

* Action items that may be voted on by Committee. **Public comment is limited to three minutes.**

AFFIDAVIT OF POSTING

Notice/agenda of a meeting of the Clark County Regional Opioid Task Force, scheduled for Saturday, January 20, 2024 at 9:00 a.m., was posted per Open Meeting Law requirements at the following locations:

Clark County Government Center Lobby
https://notice.nv.gov

CLARK COUNTY REGIONAL OPIOID TASK FORCE
COMMISSION CHAMBERS
CLARK COUNTY GOVERNMENT CENTER
500 S. GRAND CENTRAL PARKWAY
LAS VEGAS, NEVADA 89155
THURSDAY, MARCH 14, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse.

MEETING MINUTES

1. Call to Order and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:03 p.m.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Meambi Newbern-Johnson
Rosa O'Bannon
Eboni Washington
Brian O'Neal
Thomas Alfreda
Geoconda Hughes
BachTrinh Dang
Jerry Cade
Brandon Delise
Jessica Johnson

Not Present:
Chelsi Cheatom
Dolletta Mitchell
Greg Theobald

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

Anjali Reddy, a Registered Nurse with Behavioral Health Group, introduced the Nevada Opioid Treatment Association (NOTA), whose primary focus is stabilizing and maintaining individuals who are undergoing withdrawal thorough outpatient treatment, while utilizing medication assisted treatment and counseling.

3. *Approval of Minutes of meeting on January 20, 2024 *(For possible action)*

A motion was made by Eboni Washington to approve the Minutes from January 20, 2024, second motion made by Jerry Cade. The motion was unanimously approved.

4. *Approval of Agenda for March 14, 2024 *(For possible action)*

A motion was made by Brandon Delise to approve the Agenda for March 14, 2024, second motion made by Jerry Cade. The motion was unanimously approved.

5. **Receive Presentation from Nevada Department of Health and Human Services Office of Analytics (*For discussion only)***

Introduction by Kyra Morgan, State Biostatistician for the Nevada Department of Health and Human Services, followed by a presentation by Natalie Bladis, Biostatistician III on Opioid Data Sources and Reporting. The presentation reviewed state databases and resources that track substance use; publicly available dashboards and reports; and areas of further study that the Office of Analytics is working on or areas that they have proposals of gaps to fill.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

6. **Receive Presentation from the Attorney General's Substance Use Response Working Group (*For discussion only)***

Presentation by Terry Kerns, Substance Abuse/Law Enforcement Coordinator on the Substance Use Response Working Group's (SURG) structure, mandates, and reporting; to bring awareness of other agencies working opioid matters; opioid reporting; and an overview of the guidelines/toolkits that SURG has used.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

7. **Open discussion for future agenda items. *(For discussion only)***

At this time, Chair Rouse asked if Task Force members have recommendations on future agenda items or comments and suggestions.

Jerry Cade mentioned a desire to hear from the Southern Nevada Opioid Task Force to learn what they are doing and hear their perspective on Southern Nevada.

Brian O'Neal would like to see a data break down of different medications, with narrower therapeutic ranges, (ex: morphine vs Fentanyl vs codeine), something that is less potent but with a higher likelihood to result in overdose due to miscalculation of the dose.

Chair Rouse responded that the Coroner's Office can break down the data by drug and recommended that the Task Force receive a presentation from the Coroners' Office. This presentation will explain the type of data that is collected, gaps in resources, and reasons why there is a delay in reporting.

Jessica Johnson is looking forward to a presentation from the Coroner's Office and Southern Nevada Health District on how the data is translated at the local level, and from Mr. Delise who also monitors other resources.

BachTrinh Dang asked if there is a way to get information on whether the overdose is the primary or secondary cause of death. Chair Rouse responded that the data is tracked and reported on the death certificate by the coroner.

Jerry Cade wondered how the coroner will get the overdose information if a physician omits the opioid overdose language when signing the death certificate. Chair Rouse responded that any deaths that are suspected to be from non-natural causes are required to be investigated by the Clark County Coroner's Office. The ones that would be missed are the ones who don't get reported. She recommends education on death certification and reporting.

BachTrinh Dang asked if there is a way to distinguish if the drugs were prescribed or obtained illegally? Chair Rouse responded that this information is collected, that sometimes it is difficult to assess, and that the Prescription Drug Monitoring Database is utilized to determine what drugs have been prescribed versus what drugs may have been obtained illicitly. A lot of that data is captured within the reports.

Geoconda Hughes commented that the hospitals look at PDMP if someone comes in with an overdose to see if it is something that they were prescribed or bought outside of prescription.

Jessica Johnson disclosed that she is the Chair of Southern Nevada Opioid Advisory Council and would be happy to connect with her co-chair about a future presentation to the Task Force.

8. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

There were no comments from the public.

9. Adjournment

A motion to adjourn was made by Jerry Cade, second motion made by Brian O'Neal. The motion was unanimously approved.

Meeting was adjourned at 3:05 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
COMMISSION CHAMBERS
CLARK COUNTY GOVERNMENT CENTER
500 S. GRAND CENTRAL PARKWAY
LAS VEGAS, NEVADA 89106
THURSDAY, APRIL 18, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse.

MEETING MINUTES

1. Call to Order, Invocation, and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:00 p.m.

Invocation by Reverend Will Rucker.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Eboni Washington
Greg Theobald
Brian O'Neal
Jessica Johnson
Brandon Delise
Jerry Cade
BachTrinh Dang
Geoconda Hughes
Thomas Alfreda
Chelsi Cheatom
Dolletta Mitchell

Not Present:
Rosa O'Bannon
Meambi Newbern-Johnson

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

Dr. Dinita Smith, Clinic Director at Dr. Miriam and Sheldon Adelson Clinic, speaking on behalf of the Nevada Opioid Treatment Association (NOTA), asked that NOTA be added to the agenda in the future. Dr. Smith would like to present about the work that they do and how they are tackling the opioid crisis.

3. ***Approval of Minutes of meeting on March 14, 2024** ***(For possible action)***

A motion was made by Jerry Cade to approve the Minutes from March 14, 2024, second motion made by Brian O'Neal. The motion was unanimously approved with amendments to Item 1.

4. ***Approval of Agenda for April 18, 2024** ***(For possible action)***

A motion was made by Eboni Washington to approve the Agenda for April 18, 2024, second motion made by Jerry Cade. The motion was unanimously approved.

5. **Data discussion** ***(For discussion only)***
   a. **Clark County Coroner's Office**
   b. **Southern Nevada Health District**

Presentation by Clark County Coroner Melanie Rouse representing the Clark County Office of the Coroner/Medical Examiner. Overview of the office, accreditation standards, processes, timelines, trends, death certificate, and review of death data from October 1, 2023 to March 24, 2024.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

Presentation by Brandon Delise, Sr. Epidemiologist at the Southern Nevada Health District, providing an overview of opioid overdose indicators. Review of data sources for fatal and non-fatal drug overdose indicators and other indicators. Recommendation that the committee form a working group or subcommittee that can operate monthly and is exempt from open meeting laws.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

6. **Receive Presentation from Southern Nevada Opioid Advisory Council (SNOAC)** ***(For discussion only)***

Presentation by Jessica Johnson and Jamie Ross on the Southern Nevada Opioid Advisory Council with an overview of SNOAC, structure, gaps, and recommendations. Recommendations to continue to support evidence-based community efforts to drive change; utilizing best practice frameworks for task force structure and decision making; and prioritize approaches and interventions that save lives.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

7. **Receive Presentation from City of Henderson on Fentanyl Awareness Campaign** ***(For discussion only)***

Presentation by Lisa Corrado, Director of Community Development and Services at the City of Henderson, on the City of Henderson's Fentanyl Awareness Campaign that focuses on youth prevention.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. There were no questions.

8. **Open discussion for future agenda items.** ***(For discussion only)***

At this time, Chair Rouse asked if Task Force members have recommendations on future agenda items or comments and suggestions.

Chair Rouse recommends adding the suggestion received from Southern Nevada Health District about the development of a subcommittee.

Jamie Sorenson is interested in hearing from law enforcement or first responders in terms of the emergency response, policies, resources and tools that they need to coordinate response models; from family members who tried to access resources and services or support; from the education system or school district as a matter of prevention, the curriculums, the prevalence, and current issues that they are seeing in younger populations; and from treatment providers such as Crossroads, Bridge Counseling, or other provider for a perspective to make recommendations relative to recovery resources and treatment.

Eboni Washington would like to hear from providers about gaps in services.

Jerry Cade likes the idea of hitting all the categories that Jessica presented on prevention rescue treatment and

recovery to see what exists.

9. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

Trey Delap, Director of Group Six Partners, commented on the challenges that AB132 faced before being passed, how it gained support and what he hopes the committee will accomplish.

10. Adjournment

A motion to adjourn was made by Jerry Cade, second motion made by Brian O'Neal. The motion was unanimously approved.

Meeting was adjourned at 3:59 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
COMMISSION CHAMBERS
CLARK COUNTY GOVERNMENT CENTER
500 S. GRAND CENTRAL PARKWAY
LAS VEGAS, NEVADA 89155
THURSDAY, JULY 18, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse.

MEETING MINUTES

1. Call to Order, Invocation, and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:00 p.m.
Invocation by Reverend Will Rucker.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Jessica Johnson
Brandon Delise
Meambi Newbern-Johnson
Thomas Alfreda
Chelsi Cheatom
Greg Theobald
Brian O'Neal
Jerry Cade
BachTrinh Dang

Not Present:
Rosa O'Bannon
Geoconda Hughes
Dolletta Mitchell

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Minutes of meeting on April 18, 2024 *(For possible action)*

A motion was made by Brian O'Neal to approve the Minutes from April 18, 2024, second motion made by Brandon Delise. The motion was unanimously approved.

4. *Approval of Agenda for July 18, 2024 *(For possible action)*

A motion was made by Brandon Delise to approve the Agenda for July 18, 2024, second motion made by Brian O'Neal. The motion was unanimously approved.

5. ***Announcement of vacancy and direct staff to replace Task Force member representation for Department of Juvenile Justice Services.** ***(For possible action)***

Chair Rouse announced that Task Force member Eboni Washington left the County and expressed gratitude for her service to the committee and County. Chair Rouse asked staff to recruit for a replacement for representation from the Department of Juvenile Justice Services before the September meeting.

A motion was made by Jerry Cade to approve staff to recruit for a replacement for representation from the Department of Juvenile Justice Services, second motion made by Meambi Newbern-Johnson. The motion was unanimously approved.

6. ***Identify 2 members to review and bring back cases to the committee for review and discussion.** ***(For possible action)***

Chair Rouse suggested that the committee task the representatives from the Clark County Coroner and Southern Nevada Health District with identifying death cases from the zip codes in Clark County with the highest numbers of opioid overdose fatalities. The goal is to identify cases in the next few months to bring to the September meeting for the Task Force to review while complying with the guidelines from Assembly Bill 132.

Jerry Cade commented that it is a great idea.

A motion was made by Jerry Cade to approve death case reviews by the Clark County Coroner and Southern Nevada Health District representatives, second motion made by Greg Theobald. The motion was unanimously approved.

13. **Receive presentations from** ***(For discussion only)***
    a. **Las Vegas Metropolitan Police Department Overdose Response Team**
    b. **The Southern Nevada Post-Overdose Response Team (SPORT)**

Captain Michelle Tavarez from the Las Vegas Metropolitan Police Department Overdose Response Team (ORT) presented an overview of the Overdose Response Team.

Elizabeth Adelman and Treva Palmer from the Southern Nevada Post Response Team (SPORT) presented an overview of the Post-Overdose Response Team (SPORT).

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

7. **Receive presentations from individual/families seeking or have utilized community service related to opioids** ***(For discussion only)***
    c. **Tina**
    d. **Maurelle** (did not present)
    e. **Kevin** (did not present)

Tina, an individual in long-term recovery, discussed her experience with addiction to opioids and her journey to recovery with the help of the Foundation for Recovery.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

8. **Receive presentation from Nevada Opioid Treatment Association (NOTA)** ***(For discussion only)***

Introduction by Greg Bailor on behalf of Silver State Government Relations and Nevada Opioid Treatment Association (NOTA). Erin Donohue, Regional Director of Acadia Healthcare Comprehensive Treatment Centers (CTC) and NOTA member, presented an overview of NOTA, opioid treatment providers, gaps, and recommendations.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

9. Receive presentation from Crossroads of Nevada *(For discussion only)*

Introduction by Paul Vautrinot, Executive Vice President of Crossroads of Southern Nevada. Krista Hales, Lauren Griffy, and James June from Crossroads presented a comprehensive overview of Crossroads, including the various services provided, treatment and programs, and community awareness.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

10. Receive presentation from Bridge Counseling *(For discussion only)*

Dan Ficalora, Clinical Director at Bridge Counseling, presented a comprehensive overview of Bridge Counseling, their focus on outpatient treatment and behavioral health, services provided, overview of facilities, expansion goals, and community impact.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

11. Receive presentation from Clark County Fire Department *(For discussion only)*

Assistant Fire Chief Brian O'Neal from the Clark County Fire Department presented on the first responder perspective, opiate trends, access to resources, gaps, and recommendations.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

12. Discussion of future agenda items *(For discussion only)*

At this time, Chair Rouse asked if Task Force members have recommendations on future agenda items.

Chair Rouse received a request for the committee to summarize information that has been submitted this far and to include any requests from the presenters.

Jessica Johnson wondered about the task force's interest in more upstream primary prevention programming. Thinking of some areas that may address more of the social determinants such as housing, transportation, and to hear about primary prevention programming that might be happening and what some of the barriers, capacity, or issues might be.

Chair Rouse recommended that the Task Force have working virtual meetings to help facilitate the drafting of the report and the recommendations from the committee. A motion to add virtual meetings was made by Chair Rouse, second motion made by Jerry Cade. The motion was unanimously approved.

Chelsi Cheatom would like to hear from local harm reduction centers or syringe exchange. Since they are working on the ground with individuals who are currently using opioids and to hear their data.

14. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

Keith Shulman, a retired physician, commented that there is an organization called OFR and PHAST that is a private intergovernmental research organization that gives a lot of resources to opioid task force and can help to coordinate data. Keith also thinks that qualitative stories add a lot to the statistics and that looking at each case will provide more information.

15. Adjournment

A motion to adjourn was made by Jerry Cade, second motion made by Brian O'Neal. The motion was unanimously approved.

Meeting was adjourned at 4:16 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
TELECONFERENCE
THURSDAY, AUGUST 29, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. The public is invited to comment.

MEETING MINUTES

1. Call to Order and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:00 p.m.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Jessica Johnson
Meambi Newbern-Johnson
Thomas Alfreda
Jerry Cade
Rosa O'Bannon
Geoconda Hughes
Dolletta Mitchell
Chelsi Cheatom
BachTrinh Dang
Brandon Delise

Not Present:
Greg Theobald
Brian O'Neal

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Minutes of meeting on July 18, 2024 *(For possible action)*

A motion was made by Vice Chair Sorenson to approve the Minutes from July 18, 2024, second motion made by Jerry Cade. The motion was unanimously approved.

4. *Approval of Agenda for August 29, 2024 *(For possible action)*

A motion was made by Jerry Cade to approve the Agenda for August 29, 2024, second motion made by Jessica Johnson. The motion was unanimously approved.

5. Review report requirements and discuss recommendations for the final report *(For discussion only)*

Chair Rouse shared the draft for the final report that has been formatted to meet the requirements established by Assembly Bill 132. The members were informed of the presentations for the upcoming September 19th meeting.

Chair Rouse requested that members prepare recommendations to share at the October 3rd virtual meeting to ensure that the Committee can work on the draft of the report.

6. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

Chair Rouse reiterated to the members to begin thinking of how they will collaborate on the final report and to bring the recommendations to the October 3rd meeting.

7. Adjournment

A motion to adjourn was made by Jerry Cade, second motion made by Vice Chair Sorenson. The motion was unanimously approved.

Meeting was adjourned at 2:13 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
COMMISSION CHAMBERS
CLARK COUNTY GOVERNMENT CENTER
500 S. GRAND CENTRAL PARKWAY
LAS VEGAS, NEVADA 89155
THURSDAY, SEPTEMBER 19, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse.

MEETING MINUTES

1. Call to Order, Invocation, and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:00 p.m.
Invocation by Pastor Brad Beckman.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Meambi Newbern-Johnson
Rosa O'Bannon
Greg Theobald
Brian O'Neal
Dolletta Mitchell
Jessica Johnson
Brandon Delise
Thomas Alfreda
Geoconda Hughes
Jerry Cade

Not Present:
BachTrinh Dang
Chelsi Cheatom
Alexa Rodriguez

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Minutes of meeting on August 29, 2024 *(For possible action)*

A motion was made by Meambi Newbern-Johnson to approve the Minutes from August 29, 2024, second motion made by Brian O'Neal. The motion was unanimously approved.

4. *Approval of Agenda for September 19, 2024 *(For possible action)*

A motion was made by Vice Chair Sorenson to approve the Agenda for September 19, 2024, second motion made by Brandon Delise. The motion was unanimously approved.

5. **Introduction of new member, Alexa Rodriguez, representing Department of Juvenile Justice Services.**
Chair Rouse announced that Alexa Rodriguez has been appointed to represent the Department of Juvenile Justice Services.

6. **Announcement of Greg Theobald's resignation.**

Chair Rouse announced that Task Force member Greg Theobald is resigning and congratulated him on his retirement. A replacement for representation is not needed since it is nearing the end of the Task Force, and Greg Theobald will submit his recommendations for the report prior to his departure.

7. **Receive presentation from Trac-B Exchange.** ***(For discussion only)***

Rick Reich, Executive Director at Trac-B Exchange, presented a comprehensive overview of harm reduction, outreach efforts, and distribution of products.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

8. **Receive presentation from PACT Coalition.** ***(For discussion only)***

Ayla Babakitis, Manager at PACT Coalition, presented an overview of PACT Coalition, how opioid misuse prevention works in the community, types of prevention, harm reduction distribution sites, the impact of adverse childhood experiences (ACE), and recommendations.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

9. **Presentation of opioid overdose fatality cases reviewed.** ***(For discussion only)***

Melanie Rouse from Clark County Office of the Coroner/Medical Examiner and Brandon Delise from Southern Nevada Health District shared their findings from the opioid death reviews. A systemic review of opioid overdose fatalities that occurred on or after October 1, 2023, and of the zip codes of Clark County with the highest number of opioid overdose fatalities were conducted.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

10. **Presentation from staff on recommendations submitted to date from prior presenters.** ***(For discussion only)***

Sue Vang, Senior Management Analyst, provided a summary of past presentations that the Task Force received; including a compilation of gaps, social determinants of health, opportunities for collaboration, and recommendations that were suggested by various presenters.

At this time, Chair Rouse asked if there were any questions or comments regarding the presentation. Interested parties addressed their questions, comments, and concerns regarding the presentation.

11. **Recommendations for final report.** ***(For discussion only)***

Chair Rouse requested that each member prepare a list of recommendations respective to their area of expertise relating to the requirements of Assembly Bill 132 to share at the next meeting.

12. **Discussion of future agenda items.** ***(For discussion only)***

At this time, Chair Rouse asked if Task Force members have recommendations on future agenda items.

Jessica Johnson mentioned that a recently prepared a Needs Assessment by Clark County and the Southern Nevada Health District is a resource that can be helpful to Task Force members and that included in the report is an attachment that focuses on stigma and harm reduction. In addition, a team at the Southern Nevada Health District worked with Mr. Reich and a researcher out of John Hopkins University on a paper following the implementation of vending machines that shows that 41 opioid overdose deaths were averted due to that implementation.

Chair Rouse asked the committee members to review the outline of the draft that will be used for the final report.

13. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

14. Adjournment

A motion to adjourn was made by Jerry Cade, second motion made by Geoconda Hughes. The motion was unanimously approved.

Meeting was adjourned at 3:37 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
TELECONFERENCE
THURSDAY, OCTOBER 3, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. The public is invited to comment.

MEETING MINUTES

1. Call to Order and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:00 p.m.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Brian O'Neal
Rosa O'Bannon
BachTrinh Dang
Brandon Delise
Dolletta Mitchell
Geoconda Hughes
Jerry Cade
Jessica Johnson
Thomas Alfreda
Meambi Newbern-Johnson
Chelsi Cheatom
Alexa Rodriguez

Not Present:
Greg Theobald

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Agenda for October 3, 2024 *(For possible action)*

A motion was made by Jerry Cade to approve the Agenda for October 3, 2024, second motion made by Meambi Newbern-Johnson. The motion was unanimously approved.

4. *Approve Task Force members' access to work on live draft document during meeting. *(For possible action)*

Chair Rouse asked members to collaborate on a shared document during the Task Force meeting. Members wrote their remarks and suggestions in the final report's draft.

A motion was made by Jerry Cade to approve access to work on live draft of document, second motion made by Brian O'Neal. The motion was unanimously approved.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
TELECONFERENCE
THURSDAY, OCTOBER 3, 2024
2:00 P.M.

5. *Approve removal of Task Force members' access to live document upon meeting adjournment. *(For possible action)*

Chair Rouse advised members that access to the live document would be removed as a public meeting requirement and that additional recommendations can still be submitted to staff by email after the document link is deactivated.

A motion was made by BachTrinh Dang to approve removal of access to live draft of document, second motion made by Geoconda Hughes. The motion was unanimously approved.

6. Discuss future agenda items *(For discussion only)*

Chair Rouse stated that the draft would be reviewed and revised during the next Task Force meeting. Members were advised that specific tasks may be assigned to address any areas that require additional detail or to fill in any gaps in the report.

Chair Rouse requested that public health partners add more details regarding the current trends and issues that have been identified.

BachTrinh Dang suggested that the Committee review the evidence-based resource guide from SAMHSA called "Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System" and guidelines from the CDC, "CDC Clinical Practice Guidelines for Prescribing Opioids for Pain." These documents from CDC and SAMHSA include suggestions for successful community program implementation.

7. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

8. Adjournment

A motion to adjourn was made BachTrinh Dang, second motion made by Geoconda Hughes. The motion was unanimously approved.

Meeting was adjourned at 3:06 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
COMMISSION CHAMBERS
CLARK COUNTY GOVERNMENT CENTER
500 S. GRAND CENTRAL PARKWAY
LAS VEGAS, NEVADA 89155
THURSDAY, OCTOBER 17, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. The public is invited to comment.

MEETING MINUTES

1. Call to Order, Invocation, and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:05 p.m.
Invocation by Father Dave Casaleggio.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Meambi Newbern-Johnson
BachTrinh Dang
Brian O'Neal
Dolletta Mitchell
Jessica Johnson
Brandon Delise
Jerry Cade
Thomas Alfreda
Geoconda Hughes

Not Present:
Chelsi Cheatom
Rosa O'Bannon
Alexa Rodriguez

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Minutes of meetings on September 19, 2024. *(For possible action)*

A motion was made by Brian O'Neal to approve the Minutes from September 19, 2024, second motion made by Jerry Cade. The motion was unanimously approved.

4. *Approval of Agenda for October 17, 2024. *(For possible action)*

A motion was made by BachTrinh Dang to approve the Agenda for October 17, 2024, second motion made by Dolletta Mitchell. The motion was unanimously approved.

5. ***Review and edit working draft of the report.** ***(For possible action)***

Members of the Task Force went over the report's working draft line by line, making the necessary corrections and suggestions.

6. ***Assign Task Force members to areas of research and bring back additional information for future meeting.** ***(For possible action)***

Chair Rouse gave members the following assignments for further study or editing:

- Jessica Johnson will review the recommendations at the bottom of the document and place them under the appropriate sections of the document.
- Jamie Sorenson will make modifications to the recommendations page related to opioid overdose fatality review.
- Brandon Delise will provide updated data and revise section under data initiatives to clarify what the Task Force is looking for.
- Meambi Newbern-Johnson will narrow the scope for provider and other workforce challenges.
- Chair Rouse and staff will create subheadings for the report.
- Brian O'Neal will review and report on the fentanyl trafficking NRS statutes.
- BachTrinh Dang will revise the language about educating parents and families on trauma and childhood experiences under the community education needs section.
- Geoconda Hughes will elaborate on the added language about the implementation of evidence-based social and emotional learning/social and emotional community-based programs.
- Dolletta Mitchell will provide specific provider types to supplement the section about providing educational incentives for providers to enter the workforce.

Geoconda Hughes suggested that subheadings should directly correlate to the recommendations.

BachTrinh Dang suggested adding numbers to sections.

A motion was made by Brian O'Neal to accept the additional research and assignments that were assigned to the Committee members, second motion made by Dolletta Mitchell. The motion was unanimously approved.

7. **Discussion of future agenda items.** ***(For discussion only)***

Chair Rouse advised members that a first draft report will need to be developed during the next meeting.

8. **Public Comment**

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

David Gomez, President of Nevada Peace Alliance, shared his personal experiences and ideas. Mr. Gomez would like to see treatment facilities strategically placed in easily accessible, high-need locations in the community.

9. **Adjournment**

A motion to adjourn was made by BachTrinh Dang, second motion made by Geoconda Hughes. The motion was unanimously approved.

Meeting was adjourned at 3:46 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
TELECONFERENCE
WEDNESDAY, OCTOBER 30, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. The public is invited to comment.

MEETING MINUTES

1. Call to Order and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:00 p.m.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
BachTrinh Dang
Brandon Delise
Brian O'Neal
Chelsi Cheatom
Jerry Cade
Jessica Johnson
Meambi Newbern-Johnson
Rosa O'Bannon
Thomas Alfreda
Dolletta Mitchell

Not Present:
Geoconda Hughes
Alexa Rodriguez

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Minutes of meetings on October 3, 2024 and October 17, 2024. *(For possible action)*

A motion was made by Meambi Newbern-Johnson to approve the Minutes from October 3, 2024 and October 17, 2024, second motion made by Jerry Cade. The motion was unanimously approved with amendments to item 6 from the October 17, 2024 meeting.

4. *Approval of Agenda for October 30, 2024. *(For possible action)*

A motion was made by Jerry Cade to approve the Agenda for October 30, 2024, second motion made by Vice Chair Sorenson. The motion was unanimously approved.

5. *Review and edit working draft of report. *(For possible action)*

Members of the Task Force went over the report's working draft, making the necessary modifications and assigning tasks as needed.

Chair Rouse gave members the following tasks for further study or editing:

Jessica Johnson will bring additional information on hours of operations from existing service providers.

Brandon Delise and Chair Rouse will review national standardization models for opioid fatality reviews to help guide scope and objectives

A motion was made by BachTrinh Dang to approve the document as an official first draft of the report, second motion made by Dolletta Mitchell. The motion was unanimously approved.

6. Discuss future agenda items. ***(For discussion only)***

Chair Rouse recommended that the Task Force finish reviewing the last two pages of the draft and begin preparing a final draft of the report.

7. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

8. Adjournment

A motion to adjourn was made by Vice Chair Sorenson, second motion made by Jerry Cade. The motion was unanimously approved.

Meeting was adjourned at 3:28 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
COMMISSION CHAMBERS
CLARK COUNTY GOVERNMENT CENTER
500 S. GRAND CENTRAL PARKWAY
LAS VEGAS, NEVADA 89155
WEDNESDAY, NOVEMBER 13, 2024
2:00 P.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. The public is invited to comment.

MEETING MINUTES

1. Call to Order, Invocation, and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 2:02 p.m.
Invocation by Father Serge.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Jessica Johnson
Brandon Delise
BachTrinh Dang
Geoconda Hughes
Thomas Alfreda
Chelsi Cheatom
Dolletta Mitchell
Rosa O'Bannon
Meambi Newbern-Johnson
Jerry Cade

Not Present:
Brian O'Neal
Alexa Rodriguez

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

Keith Shulman suggested that the committee address extending the needle exchanges and opening an overdose prevention center. In addition, Mr. Shulman suggested that the overdose fatality reviews should focus on one or two cases each month and compiling a very detailed analysis of those cases.

3. *Approval of Minutes of meetings on October 30, 2024. *(For possible action)*

A motion was made by Geoconda Hughes to approve the Minutes from October 30, 2024, second motion made by Dolletta Mitchell. The motion was unanimously approved.

4. ***Approval of Agenda for November 13, 2024.** ***(For possible action)***

A motion was made by Vice Chair Sorenson to approve the Agenda for November 13, 2024, second motion made by BachTrinh Dang. The motion was unanimously approved.

5. ***Review and edit first draft of the report.** ***(For possible action)***

A motion was made by Dolletta Mitchell to approve the review and edit of the first draft of the report, second motion made by Meambi Newbern-Johnson.

Members of the Task Force went over the report's working draft and made the necessary corrections.

6. ***Prepare and approve final draft of the report.** ***(For possible action)***

Chair Rouse moved to prepare the final draft of the report while allowing for the review of the report for grammar and formatting prior to submission. Chair Rouse recommended that staff confirm changes discussed and schedule a virtual meeting to allow the Task Force to accept the final document.

A motion was made by BachTrinh Dang to approve the final draft of the report, second motion made by Vice Chair Sorenson.

7. **Public Comment**

At this time, Chair Rouse asked if there was anyone wishing to make public comment.

Keith Shulman is unsure of the gap listed in the report regarding enhanced care coordination in the emergency rooms for individuals who arrive after an overdose and suggested mentioning that that there are not enough patient care coordinators to help with the situation. Mr. Shulman suggested highlighting the demographics in the main document and not just referring to it in the appendix.

8. **Adjournment**

A motion to adjourn was made by Jerry Cade, second motion made by Dolletta Mitchell. The motion was unanimously approved.

Meeting was adjourned at 3:23 p.m.

CLARK COUNTY REGIONAL OPIOID TASK FORCE
TELECONFERENCE
THURSDAY, NOVEMBER 21, 2024
10:30 A.M.

The Clark County Regional Opioid Task Force was created by AB132 from the 82nd Session of the 2023 Nevada Legislature and is comprised of fifteen (15) individuals appointed by the Board of Clark County Commissioners. The Task Force reviews data relating to opioid overdose fatalities and near fatalities and uses such data to identify gaps in community services relating to opioids and opioid overdose fatalities. The Task Force reviews data from existing state and community databases and, in particular, information relating to harm reduction and substance abuse. Task Force members identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. The public is invited to comment.

MEETING MINUTES

1. Call to Order and Roll Call

The Clark County Regional Opioid Task Force was called to order by Chair Rouse at 10:33 a.m.

Committee Members
Present:
Melanie Rouse, Chair
Jamie Sorenson, Vice Chair
Brian O'Neal
Brandon Delise
Jerry Cade
Dolletta Mitchell
Geoconda Hughes
Rosa O'Bannon
Chelsi Cheatom

Not Present:
Alexa Rodriguez
BachTrinh Dang
Jessica Johnson
Meambi Newbern-Johnson
Thomas Alfreda

2. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

3. *Approval of Minutes of meetings on November 13, 2024. *(For possible action)*

A motion was made by Jerry Cade to approve the Minutes from November 13, 2024, second motion made by Brian O'Neal. The motion was unanimously approved.

4. *Approval of Agenda for November 21, 2024 *(For possible action)*

A motion was made by Jerry Cade to approve the Agenda for November 21, 2024, second motion made by Geoconda Hughes. The motion was unanimously approved.

5. *Review and approve final draft of report. *(For possible action)*

Members of the Task Force reviewed the report's working draft and made changes as needed. Chair Rouse moved to accept the document as the final draft of the report while allowing staff to add a conclusion and proofread it for grammar and formatting errors before submission.

A motion was made by Jerry Cade to approve the document as the final report, second motion made by Vice Chair Sorenson.

The motion was unanimously approved.

6. Public Comment

At this time, Chair Rouse asked if there was anyone wishing to make public comment.
There were no comments from the public.

7. Adjournment

Chair Rouse expressed gratitude to the members and staff for their participation in the Task Force and for their contributions to the report.

Geoconda Hughes thanked Chair Rouse for all her hard work on the report and for the staff's editing efforts.

Vice Chair Sorenson agreed that Chair Rouse did a wonderful job and thanked her for all her hard work.

A motion to adjourn was made by Jerry Cade, second motion made by Brian O'Neal. The motion was unanimously approved.

Meeting was adjourned at 11:00 a.m.

Appendix T

2024

Opioid Use/Opioid Use Disorder Community Needs Assessment for Clark County and the Southern Nevada Health District

PREPARED BY CLARK COUNTY AND THE SOUTHERN NEVADA HEALTH DISTRICT

Table of Contents

Figures

Tables

Executive Summary

The Fund for a Resilient Nevada (FRN) was established in Nevada Revised Statutes (NRS) 433.712 through 433.744 and is specific to the State's portion of opioid litigation recoveries. It is administered by the Nevada Department of Health and Human Services (DHHS) Director's Office, as identified in NRS 433.732, utilizing the recoveries resulting from litigation concerning the manufacture, distribution, sale, or marketing of opioids. FRN monies are deposited through the Attorney General's Office from recoveries from opioid litigation, settlements, and bankruptcies.

Pursuant to NRS 433.734, one of the DHHS's responsibilities is the development of the statewide needs assessment and a statewide plan to identify priorities. FRN recoveries must be used to address risk, harms and impacts of the opioid crisis on the state, using a data-driven and evidence-based approach.

A regional, local, or tribal government entity that receives a grant pursuant to paragraph (b) of Subsection 2 of NRS 433.738 shall conduct a new needs assessment and update its plan no less than every four (4) years *as designated in NRS 433.740 through 433.744; or at the direction of the DHHS. The Nevada Department of Health and Human Services may coordinate with and provide support to regional, local, and tribal governmental entities in conducting needs assessments and developing plans.*

The requirements of NRS 433.712 through 433.744 were developed using the following guiding principles identified by Johns Hopkins, Bloomberg School of Public Health's Principles for the Use of Funds from Opioid Litigation:

1. Spend money to save lives
2. Use evidence to guide spending.
3. Invest in youth prevention.
4. Focus on racial equity.
5. Develop a fair and transparent process for deciding where to spend the funding.

This document serves as the county-level needs assessment and plan for the expenditure of funds for both Clark County and the Southern Nevada Health District.

Firstly, this document provides an overview of Clark County and the Southern Nevada Health District. Specific information is provided to understand the current demographics of Southern Nevada and how those changing demographics require both entities to continue to change the way that service delivery is provided to meet the changing community.

The document then summarizes how this document took a multi-pronged community engagement approach, utilizing qualitative and quantitative assessments to engage the community, stakeholders, and persons impacted by the use of opioids and other substances. Those analyses provide insight into opioid use in the community, while also creating valuable relationships for knowledge and resource sharing.

Thirdly, this document provides quantitative data regarding the impact of opioid use and misuse in Clark County. Data is presented from a myriad of sources to understand the true impact of opioid use for all geographic areas of Clark County, as well as demographic groups, including sex, racial and

ethnic minority status, and age. Additional data is presented to provide an understanding into how opioid use disorder has impacted children in the community, including referrals for child welfare services.

While this document presents many areas of concern surrounding opioids in Clark County, this document also presents information on local promising programs. This includes targeted naloxone saturation and medication-assisted treatment in the Clark County Detention Center.

Finally, in accordance with S.B. 390 of the 2021 Legislative Session, this document presents an overview of funding recommendations and implementation plans. As this is a joint assessment, both Clark County and the Southern Nevada Health District present their recommended funding strategies in order to combat the opioid epidemic. All funding priorities presented are tied to the evidence presented herein. Moreover, the funding priorities have clear ways to measure the impact, whether quantitatively or qualitatively, to continue to understand the impact of the proposed/continuing programs to combat the epidemic.

In short, this document provides a strong overview of the current state of the opioid epidemic in the Southern Nevada community along with recommendations for funding to combat the epidemic. The current state is presented using both primary and secondary sources in order to provide an accurate and demonstrative understanding to allow for the funding priorities to be representative of the needs.

Acknowledgements

The Opioid Use/Opioid Use Disorder Community Needs Assessment for Clark County and the Southern Nevada Health District would not be possible without collaboration from our community partners. Deepest thanks to the Nevada Institute for Children's Research and Policy and Southern Nevada Health District staff for conducting the community interviews. Additionally, many thanks to people with lived experience and those impacted by the opioid crisis in our community who took the time to provide feedback, assist with recommendations, and take the time to meet and discuss opioid use in Clark County.

Thank you to all of the agencies/organizations listed below for their collaboration and outreach on this needs assessment:

Clark County Coroner/Medical Examiner's Office
Clark County Department of Family Services
Clark County Department of Finance
Clark County Department of Juvenile Justice Services
Clark County Detention Center
Clark County Juvenile Court
Clark County Manager's Office
Dr. Daniel Gerrity, Southern Nevada Water Authority & University of Nevada, Las Vegas
Eighth Judicial District Court
EMPOWERED Program at Roseman University
Foundations for Recovery
Las Vegas Metropolitan Police Department
Nevada Department of Corrections
Nevada High Intensity Drug Trafficking Area
Nevada Institute for Children's Research and Policy at the University of Nevada, Las Vegas
PACT Coalition
Southern Nevada Health District
The LGBTQ+ Center of Southern Nevada
Trac-B/Impact Exchange
University Medical Center of Southern Nevada

Acronyms

A.B.	Assembly Bill
BCC:	Clark County Board of County Commissioners
BIPOC:	Black, Indigenous, and Other People of Color
CBPR:	Community-Based Participatory Research
CC:	Clark County
CCDC:	Clark County Detention Center
CCSD:	Clark County School District
CCWRD:	Clark County Water Reclamation District
CDC:	U.S. Centers for Disease Control and Prevention
CM:	Contingency Management
COWS:	Clinical Opioid Withdrawal Scale
DFS:	Clark County Department of Family Services
DHHS:	Nevada Department of Health and Human Services
DSM-V:	Diagnostic and Statistical Manual of Mental Disorders Assessment
ED:	Emergency Visits
FQHC:	Federally Qualified Health Center
HCV:	Hepatitis C Virus
HIDTA:	High Intensity Drug Trafficking Area
HIV:	Human Immunodeficiency Virus
JDTC:	Clark County Juvenile Drug Treatment Court
JJS:	Clark County Department of Juvenile Justice Services
LGBTQ+:	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual, and More
LVMPD:	Las Vegas Metropolitan Police Department
MAT:	Medication-Assisted Treatment
MOUD:	Medications for Opioid Use Disorder
MSM:	Men Who Have Sex With Mem
NDOC:	Nevada Department of Corrections
NICRP:	Nevada Institute for Children's Research and Policy
NRS:	Nevada Revised Statutes
ODTA:	Overdose Data to Action
OMB:	U.S. Office of Management and Budget
OUD:	Opioid Use Disorder
PHAB:	Public Health Accreditation Board
S.B.:	Senate Bill
SAPTA:	Substance Abuse Prevention & Treatment Agency
SDoH:	Social Determinants of Health
SNCHC:	Southern Nevada Community Health Center
SNHD:	Southern Nevada Health District
SNOAC:	Southern Nevada Opioid Advisory Council
SPORT:	Southern Nevada Post Overdose Response Team
StUD:	Stimulant Use Disorder
SUD:	Substance Use Disorder
UMC:	University Medical Center of Southern Nevada

UNLV: University of Nevada, Las Vegas
YRBSS: Youth Risk Behavior Surveillance System

[This page left blank intentionally.]

Background

2021 Legislation

The Nevada Legislature passed Senate Bill (S.B.) 390 during the 2021 Legislative Session. S.B. 390 is an act relating to behavioral health; providing for the establishment of a suicide prevention and behavioral health crisis hotline; the creation of the Fund for a Resilient Nevada; and prescribing certain procedures for local government entities to receive funds deposited into the Fund for a Resilient Nevada to address the impact of opioid use disorder and other substance use disorders. (Nevada Legislature, 2021)

S.B. 390 was developed using The Principles for the Use of Funds From the Opioid Litigation (guiding principles). (The Bloomberg School of Public Health at John Hopkins University, n.d.) The Bloomberg School of Public Health at John Hopkins University developed the guiding principles in consultation with a myriad of public health organizations. The guiding principles were presented by Nevada Attorney General Aaron Ford during a hearing on S.B.390. He provided that:

> *the guiding principles are to first, use the funds to supplement rather than supplant existing State spending; second, use funds to support programs supported by evidence-based interventions; third, use the funds to support investments in youth prevention; fourth, use the funds with a focus on racial equity, and fifth, report to the public as to which programs are being funded.*

Attorney General Ford further cited that the guiding principles had been a tool for the Nevada Department of Health and Human Services (DHHS) in their development of a plan to determine the best use of the funds. (Nevada Legislature, 2021)

(Continues on the next page)

The Principles for the Use of Funds From the Opioid Litigation

As previously mentioned, the guiding principles are comprised of five (5) main areas:

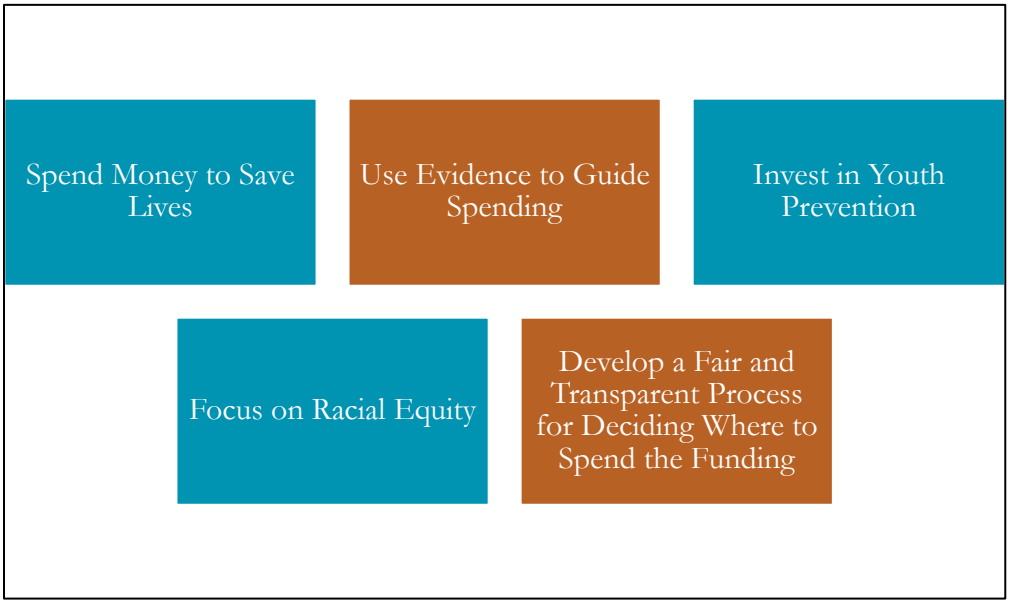


Figure 1: The Principles for the Use of Funds From Opioid Litigation

Elements of the guiding principles are consistent with policymaking recommendations. Firstly, the guiding principles recommends that any money spent should be reported to the public in a manner that allows the public to easily understand the differences being made in the community (e.g., the amount of naloxone distributed). Second, the guiding principles recommends the use of evidence when making decisions on how to spend the money. For example, "people with opioid use disorder in many residential treatment facilities are prohibited from being treated with methadone or buprenorphine, despite evidence that these medications reduce the chance of overdose death by 50% or more." (The Bloomberg School of Public Health at John Hopkins University, n.d.) Understanding the importance of using evidence when making decisions for how the opioid litigation funding is spent is vital to ensuring that gaps in treatment are addressed while still being accountable to the public. Finally, the guiding principles recommends a focus on racial equity. In the publication, it was noted that "black individuals represent just 5% of people who use drugs, but 29% of those arrested for drug offenses and 33% of those in state prison for drug offenses." (The Bloomberg School of Public Health at John Hopkins University, n.d.) It is clear in the guiding principles, as well as in policy discussions that racial equity must remain at the forefront when tackling past injustices and working to prevent fatal overdoses.

[This page left blank intentionally.]

Purpose of the Needs Assessment

This needs assessment provides a summary of the available information on trends, gaps, and needs pertaining to opioid use in Clark County, Nevada. In presenting the available information, this needs assessment uses both quantitative and qualitative data 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 the area.[1] Additionally, it provides recommendations and proposes action plans for the allocation of opioid litigation funds to ameliorate harms of opioid use. As this is a joint assessment, both Clark County and the Southern Nevada Health District present their own action plans.

[1] This is consistent with Section 9.8 (1) (b) of S.B. 390 of the 2021 Nevada Legislative Session.

[This page left blank intentionally.]

Community Overview

Clark County Overview

Clark County is a dynamic and innovative organization dedicated to providing top-quality service with integrity, respect, and accountability. With jurisdiction over the world-famous Las Vegas Strip and covering an area the size of New Jersey, Clark County is the nation's 11th-largest county and provides extensive regional services to more than 2.3 million citizens and an average of 45 million visitors a year.

Clark County is a political subdivision of the State of Nevada, established in 1909 and operated under the provisions of the general laws of Nevada. The County is governed by a seven-member Clark County Commission (County Commission) who are responsible for setting and implementing policy. The County Commission in turn hires a county manager, who is responsible for implementing policies and desired outcomes established by the County Commission and directing the day-to-day activities involved in running the County.

Clark County employs close to 10,000 employees in 38 departments. It has a fiscal year general fund budget of $2.1 billion and a total budget of $11.4 billion. The County is known for its strong ending-fund balance, overall financial strength, and an investment-quality credit rating. It retains one of the highest bond ratings of any local government in the state.

Clark County provides extensive regional services to more than 2.3 million citizens and more than 45 million visitors a year. The County provides a wide range of regional services such as the 8th-busiest airport, the state's largest public hospital, air quality compliance, protective services for abused/neglected children, foster and adoption services, health and welfare assistance, property assessment, tax collection, elections administration, as well as a criminal justice system including Courts, District Attorney, Public Defender, and Juvenile Justice services. The County also provides municipal services traditionally provided by cities. As a "city" government, Clark County responds to the needs of about one million residents in the urban and rural unincorporated areas. Service provided to the unincorporated residents include all those functions normally associated with a city, such as fire protection, roads maintenance and construction, code enforcement, animal control, sewer services, parks, and recreation, building safety, planning and development, and business licensing/enforcement.

Southern Nevada Health District

The Southern Nevada Health District (SNHD) was established through Nevada Revised Statues Chapter 439 and is directed by an eleven-member policy-making Board of Health, which provides oversight and guidance to the District Health Officer, Dr. Fermin Leguen. (Title 40: Chapter 439: Administration of Public Health, n.d.) The agency includes several divisions, that serve a full range of public health needs for over the approximate 2.3 million people that live in Clark County, and more than 45 million annual visitors.

The current divisions include Environmental Health, Disease Surveillance and Control, Community Health, Primary and Preventive Care, and a Federally Qualified Health Center (FQHC) – the Southern Nevada Community Health Center (SNCHC). Divisions are supported by the Administration Division, which includes human resources, finance, information technology, facilities, and related supports for a workforce of approximately 800 people. SNHD currently holds accreditation through the Public Health Accreditation Board (PHAB).

Clark County Demographic Data

The 2020 Decennial Census reported that Clark County's population was 2,265,461, a 16.10% increase from the 2010 Decennial Census. (U.S. Census Bureau, 2020) The United States population grew by 7.4% during the same period, thus placing Clark County and Nevada ahead of the country in terms of growth. (Jarosz, n.d.)

The 2022 American Community Survey estimated the median age in Clark County to be 38.3 years of age, with 22.2% of the entire Clark County population being under 18 years of age. (U.S. Census Bureau, 2022)

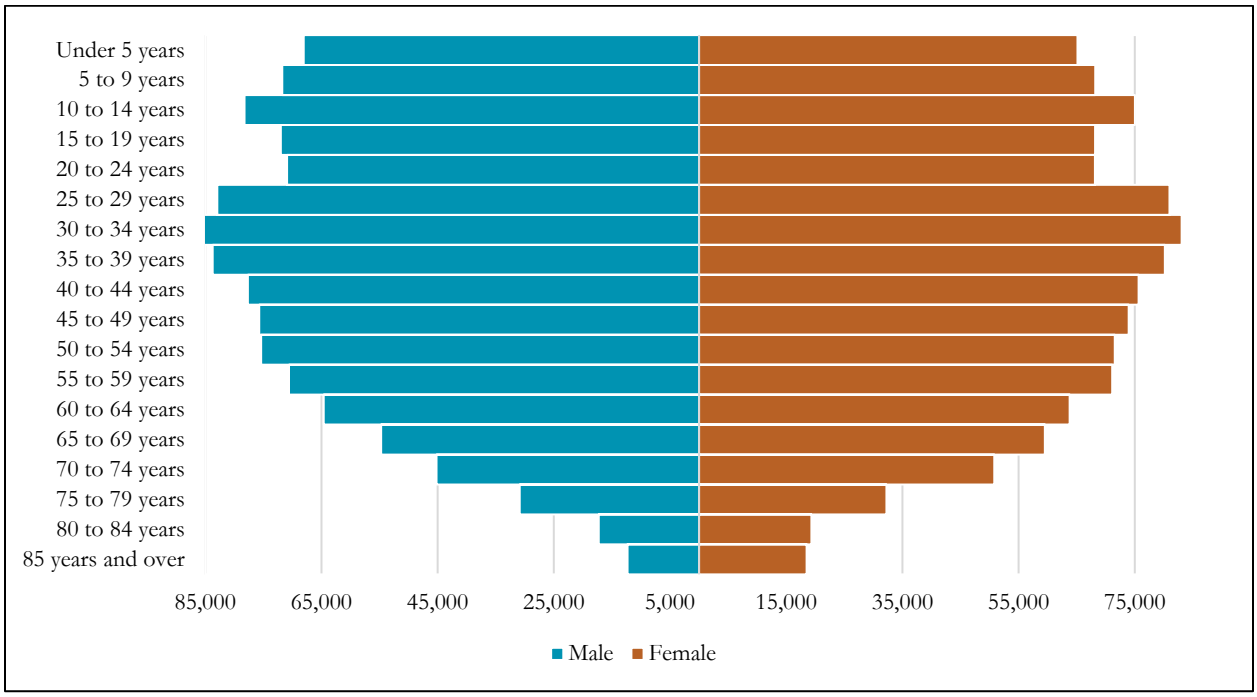


Figure 2: Median Age by Sex for Clark County
Source: (U.S. Census Bureau, 2022)

(Continues on the next page)

Over time, Clark County's population has become increasingly diverse.

Race and Hispanic Origin	
White alone (c)	67.2%
Black or African American alone (c)	13.8%
American Indian and Alaska Native (a)	1.3%
Asian alone (c)	11.2%
Native Hawaiian and Other Pacific Islander alone (a) (c)	1.0%
Two or More Races (c)	5.5%
Hispanic or Latino (b)	32.6%
White alone, Not Hispanic or Latino	38.8%

Table 1: Race and Hispanic Origin for Clark County

Sources: (U.S. Census Bureau, 2023), (U.S. Census Bureau, Updated annually), (U.S. Census Bureau, Updated annually)[2]

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so are also included in applicable race categories.
(c) Includes persons who may also identify as Hispanic or Latino.

(Continues on the next page)

[2] The U.S. Census Bureau collects race data in accordance with guidelines provided by the U.S. Office of Management and Budget (OMB), and these data are based on self-identification. The racial categories included in the Census questionnaire generally reflect a social definition of race recognized in this country and not an attempt to define race biologically, anthropologically, or genetically. In addition, it is recognized that the categories of the race item include racial and national origin or sociocultural groups. People may choose to report more than one race to indicate their racial mixture, such as "American Indian" and "White." People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

OMB requires five minimum categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race. OMB permits the Census Bureau to also use a sixth category - Some Other Race. Respondents may report more than one race.

The concept of race is separate from the concept of Hispanic origin.

In Clark County, the median household income[3] is $70,797 which is just slightly less than the median household for the United States- $74,755. The per capita income for Clark County is $36,915 which is about 90 percent of the amount in the United States- $41,804. (Census Reporter, 2022) Figure 3 summarizes the percentage of Clark County's populations broken out by household income.

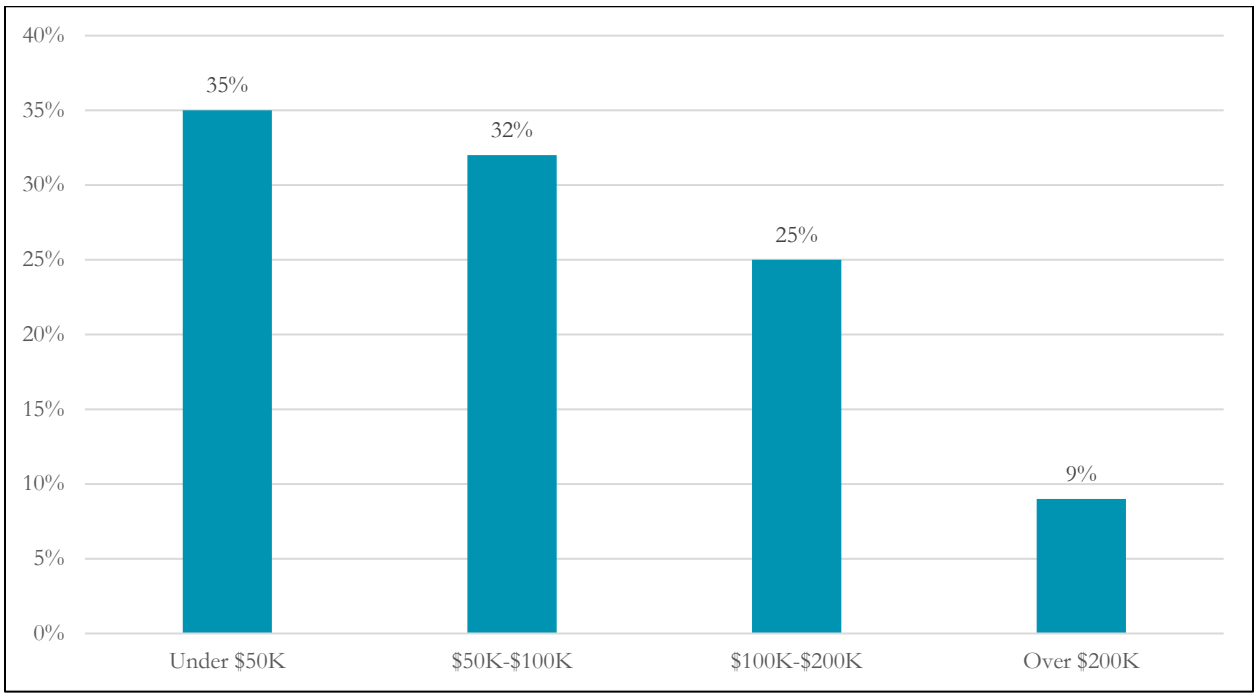


Figure 3: Median Household Income for Clark County
Source: (Census Reporter, 2022)

(Continues on the next page)

[3] Household income is defined as the income of the householder and all other people 15 years and older in the household, whether or not they are related to the householder. **Invalid source specified.**

Approximately thirteen (13) percent of persons in Clark County are living below the poverty line with 18% of children under the age of 18 falling below the poverty line. (Census Reporter, 2022) Individuals falling below the poverty line are more likely to have an opioid use disorder than those that do not fall below the poverty level. (Jones, 2017) Moreover, the 2016 National Survey on Drug Use and Health found that "individuals under the poverty line were 2.1 percentage points more likely to have misused opioids in the past twelve months than individuals above 200 percent of the poverty line." (Ghertner & Groves, Ph.D., 2018) In short, those under the poverty line are twice as likely to have an opioid use disorder.

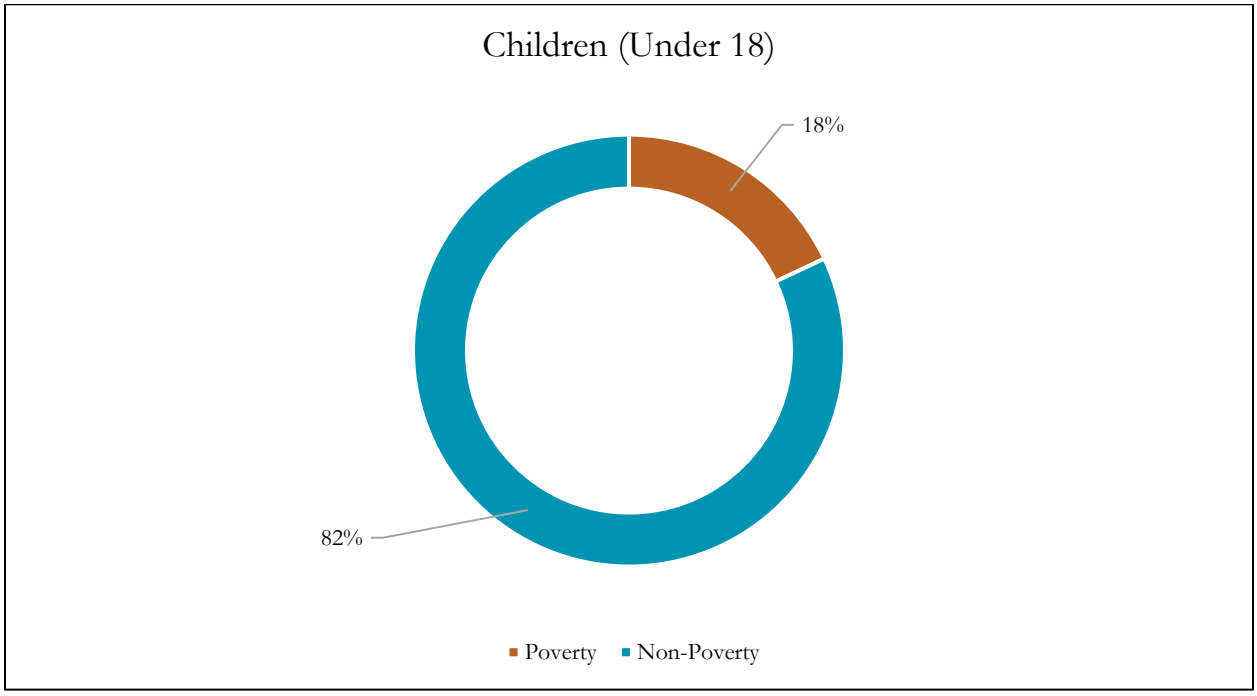


Figure 4: Children (Under 18) Below the Poverty Line in Clark County
Source: (Census Reporter, 2022)

[This page left blank intentionally.]

Community Based Participatory Research

Section 9.8 (2) (a) of S.B. 390 requires that a local government use community-based participatory research (CBPR) methods or similar methods to conduct outreach to groups impacted by the use of opioids, opioid use disorder, and other substance use disorders. Additionally, Section 9.8 (2) (b) of S.B. 390 requires outreach to governmental agencies that interact with persons or groups impacted by the use of opioids, opioid use disorder and other substance use disorders. (Nevada Legislature, 2021)

With the CBPR approach, there are numerous elements; however, CBPR rests on two (2) key principles. The first pillar is "ethical and responds to a history of exploitation of communities-especially minority and low-income communities…." (Blumenthal, 2011) The first principle is consistent with the intent of S.B. 390 and the guiding principles developed by The Bloomberg School of Public Health at John Hopkins University. It is vital that as researchers and policy practitioners consider historical mistakes in the public health arena and ensure inclusion rather exclusion when recommending solutions. Moreover, research products and policy recommendations should be provided to the community following the collection period to ensure that the impacted communities have a continued voice and a path forward. The second pillar that CBPR rests on is community engagement. (Blumenthal, 2011) Building upon the first pillar, the second pillar continues to incorporate the involvement from the community on developing solutions to allow communities to move forward and share resources. Accordingly, CBPR has often been linked to reducing health disparities. (Salimi, et al., 2012)

To achieve this goal, this needs assessment took a multi-pronged community engagement approach similar to CBPR, utilizing qualitative and quantitative assessments to engage the community, stakeholders, and persons impacted by the use of opioids and other substances. Throughout the analyses, presented herein, Clark County and SNHD collaborated with members of under-resourced community and public policy practitioners to ensure valuable relationships through sharing resources, decision-making, and knowledge.

Clark County Community Stakeholder Survey

Clark County launched an online survey to gather information and insight from community stakeholders to make recommendations for the needs assessment. The survey questions were based on an online survey conducted by Washoe County, which was initially adapted from a survey in Illinois.[4] (Pickett, Powell, Lang , & Carpenter, n.d.)

Due to a limited assessment period, convenience sampling was chosen to target community stakeholders that reside in Clark County. The survey was released by the Clark County Manager's Office to Clark County department leadership, as well as other community stakeholders. Additionally, information was distributed about the survey at the Clark County Child Welfare Summit in April 2024.

The survey was open for 20 calendar days. The survey opened on April 23rd, 2024 and closed on May 13th, 2024.

Data was analyzed using Google Forms and Microsoft Excel. There were 83 responses, with 81 respondents indicating that they resided in Clark County. The survey was only open to those respondents that said they resided in Clark County.

With all surveys, there are some limitations. For this survey, there are two (2) limitations to highlight:

1. As this is a non-random sample, there is sampling bias.
2. The survey results are not representative of all of those individuals in Clark County that are working to solve the opioid epidemic. Therefore, the results cannot be generalized.

In addition to optional demographic questions, respondents were asked about their personal impacts of opioids in their lives, their perceptions of the opioid epidemic in Clark County, existing initiatives to address the opioid epidemic in Clark County, the source of their information, disproportionately impacted populations, and questions about gaps and challenges. Furthermore, respondents were asked an open-ended question about how they would create a program to address opioid use in Clark County if resources and time were not an issue. All questions on the survey were optional after the first question about residency.

Portions of the results of the survey are presented in this section.

[4] A copy of the survey instrument is available in Appendix 1.

Figure 5 and Table 2 show that the majority of respondents did not respond that they are persons who use opioids.[5] There were two (2) respondents that marked that they were in recovery from an opioid use disorder. The largest group of respondents identified themselves as local government professionals, followed by those who work in child welfare agencies. Additionally, eleven (11) respondents indicated that they have a family member who has an opioid use disorder.

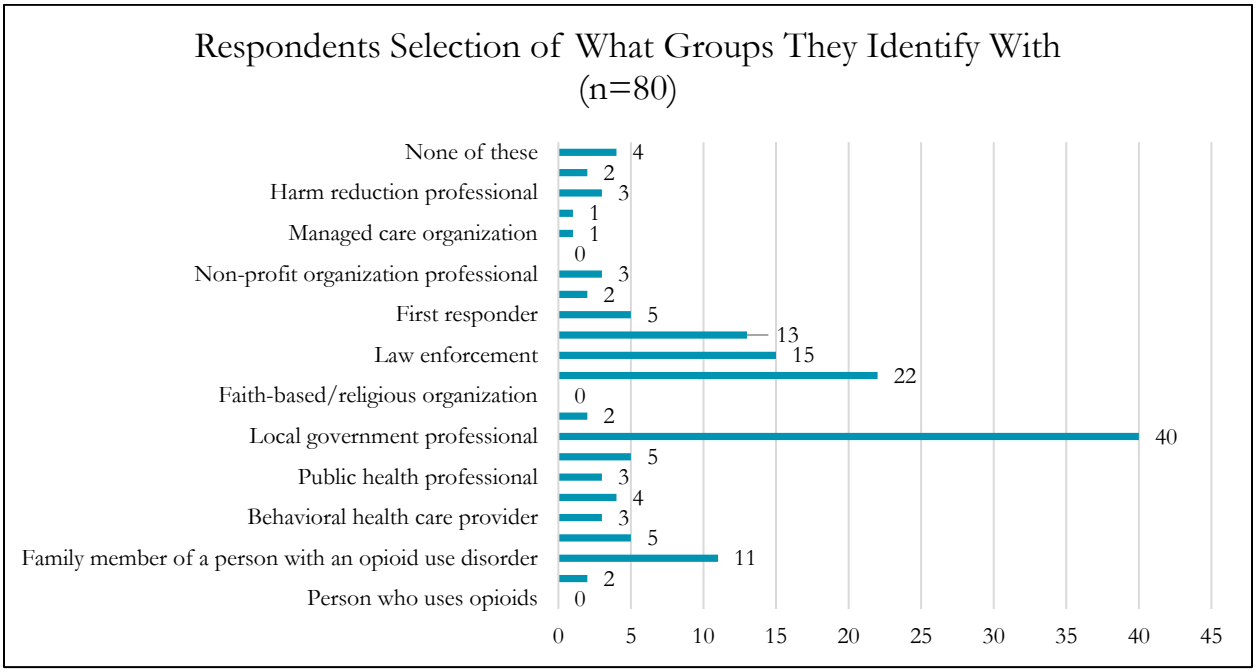


Figure 5: Respondent Selection of What Groups They Identify With

Respondent Selection of What Groups They Identify With	
Person who uses opioids	0
Person in recovery from opioid use disorder	2
Family member of a person with an opioid use disorder	11
Health care provider	5
Behavioral health care provider	3
Substance use treatment provider	4
Public health professional	3
Education professional	5
Local government professional	40
State government professional	2
Faith-based/religious organization	0
Child welfare agency	22
Law enforcement	15
Justice system professional	13
First responder	5

[5] This was a multiple response question. Sample size reflects the number of respondents, not responses.

Respondent Selection of What Groups They Identify With	
Mutual aid organization	2
Non-profit organization professional	3
Research professional	0
Managed care organization	1
Prevention professional	1
Harm reduction professional	3
Homeless services professional	2
None of these	4

Table 2: Respondent Selection of What Groups They Identify With

Figure 6 provides information about respondents have personally been impacted by opioids. Note, there were 11 responses in Figure 5 that indicated that a responder identified in a group with a family member with an opioid use. However, as shown below in Figure 6, there were 34 respondents who identified that a family member has or had an issue with opioids.

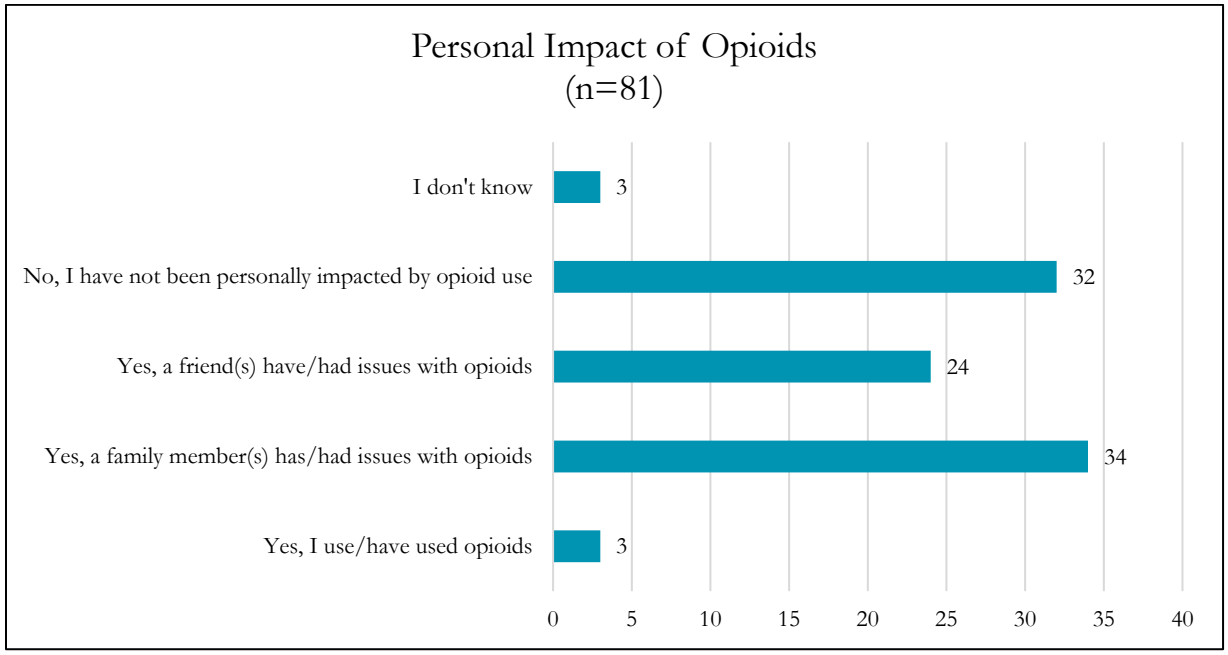


Figure 6: Personal Impact of Opioids

(Continues on the next page)

Seventy-two (72) percent of respondents indicated that some groups are more disproportionately impacted by the opioid crisis than others in Clark County.

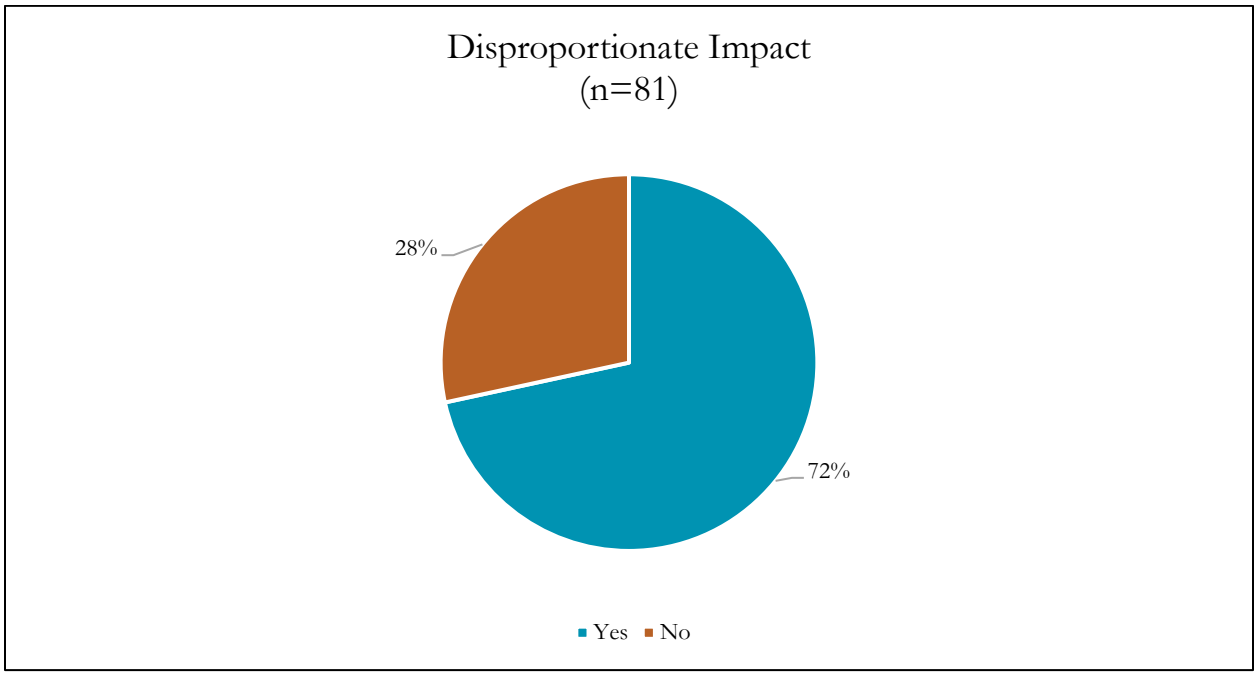


Figure 7: Disproportionate Impact

Respondents who indicated that they believe that some groups are more disproportionately impacted were asked to identify the groups that have been impacted. The top group identified were low-income households followed by communities of color. At-risk youth and those that are homeless were also identified as groups being disproportionately impacted. (See Table 3).

Group	Count of Responses
At-Risk Youth	12
Children of Opioid Users	2
Communities of Color	20
Disabled	1
Formerly Incarcerated Individuals	1
Homeless	12
Indigent	1
LGBTQ+	2
Low-Income Households	30
Mental Health	2
Other	7
Prescription Opioid Users	4
Undocumented	1
Veterans	1
Young Mothers	2
TOTAL:	**99**

Table 3: Disproportionately Impacted Groups

Respondents were asked to identify the sources of information on opioid-related issues in Clark County for the past 12 months. The majority of respondents are accessing their information about opioid-related issues via local television news, followed closely by work meetings/reports.[6]

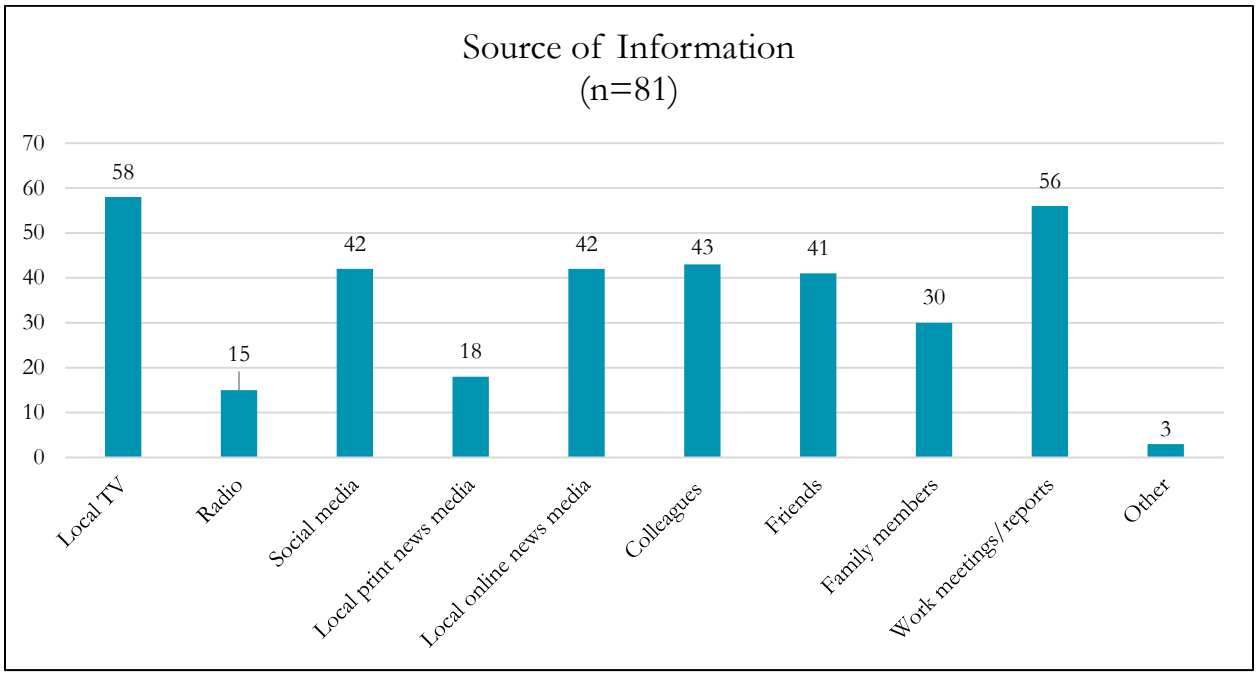


Figure 8: Source of Information for Opioid-Related Issues

(Continues on the next page)

[6] This was a multiple response question. Sample size reflects the number of respondents, not responses.

Understanding the variety of sources for opioid-related issues in the community, respondents were asked to identify their awareness of opioid-related initiatives in Clark County. The majority of respondents were aware of naloxone/Narcan training, specialty courts, and drug take back/disposal.

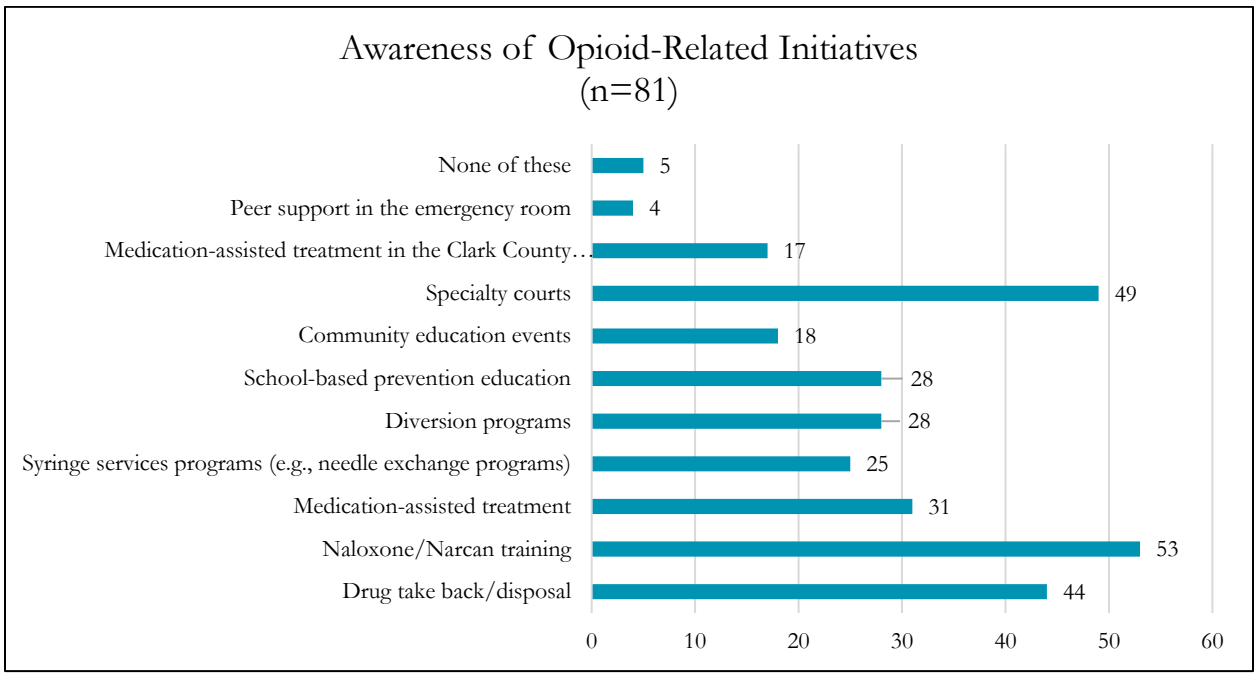


Figure 9: Awareness of Opioid-Related Initiatives

(Continues on the next page)

Respondents were asked to select the biggest opioid-related needs in Clark County. Respondents could select more than one answer, and there was no ranking associated with this question. The results of this question provide preliminary information on what other opioid-related initiatives are needed for Clark County.

The majority of responses were associated with recovery support services, public awareness, and increased access to low-barrier treatment.

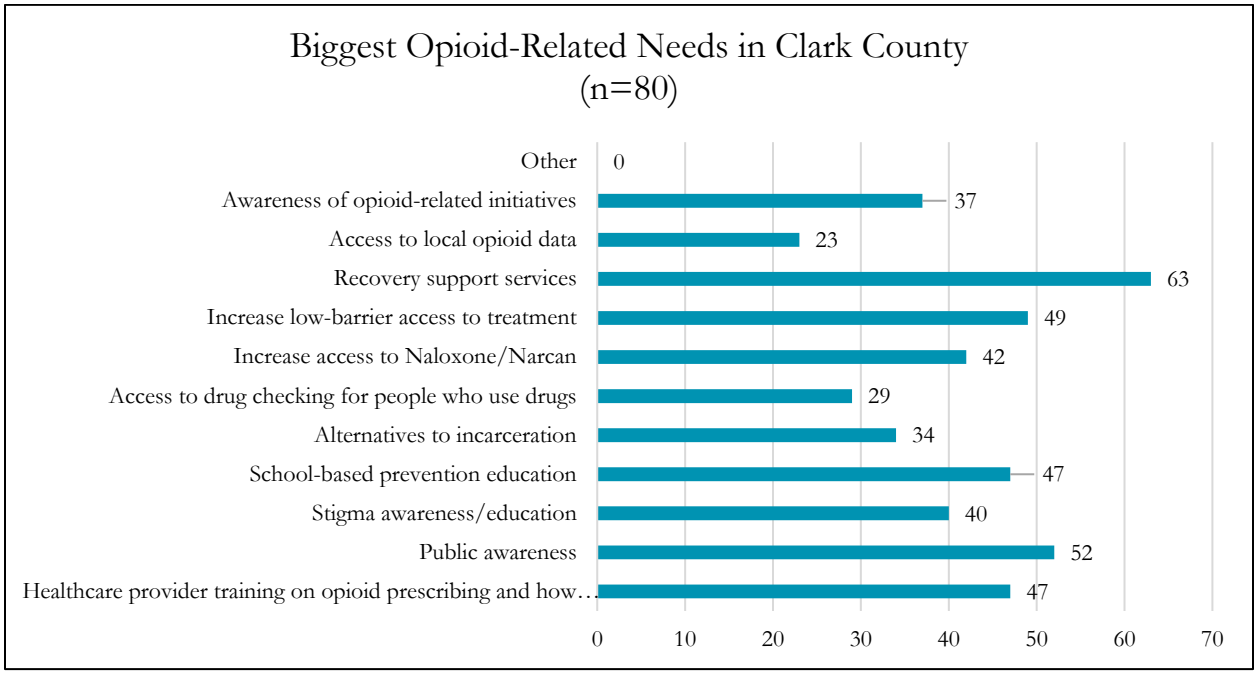


Figure 10: Biggest Opioid-Related Needs in Clark County

(Continues on the next page)

Respondents were asked to identify the strengths in Clark County to help address the opioid crisis, while also selecting gaps, barriers, and challenges to the crisis. Figure 11 highlights the strengths that were selected by respondents; respondents could select more than one strength. The top three (3) strengths that were identified are community partnerships, public awareness, and harm reduction services. In contrast, Figure 12 highlights the gaps, barriers, and challenges to the crisis. The top three (3) challenges are lack of resources (e.g., staff, funding, and programs), lack of substance use treatment services, and limited knowledge of available resources.

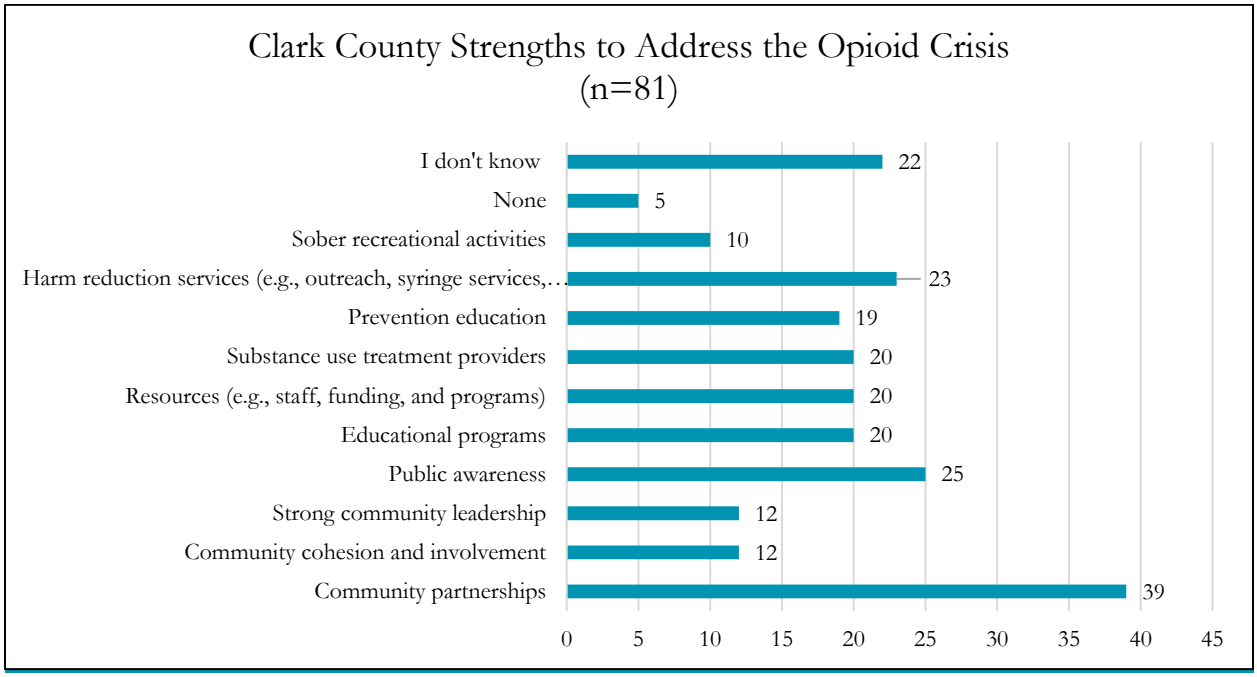


Figure 11: Clark County Strengths to Address the Opioid Crisis

(Continues on the next page)

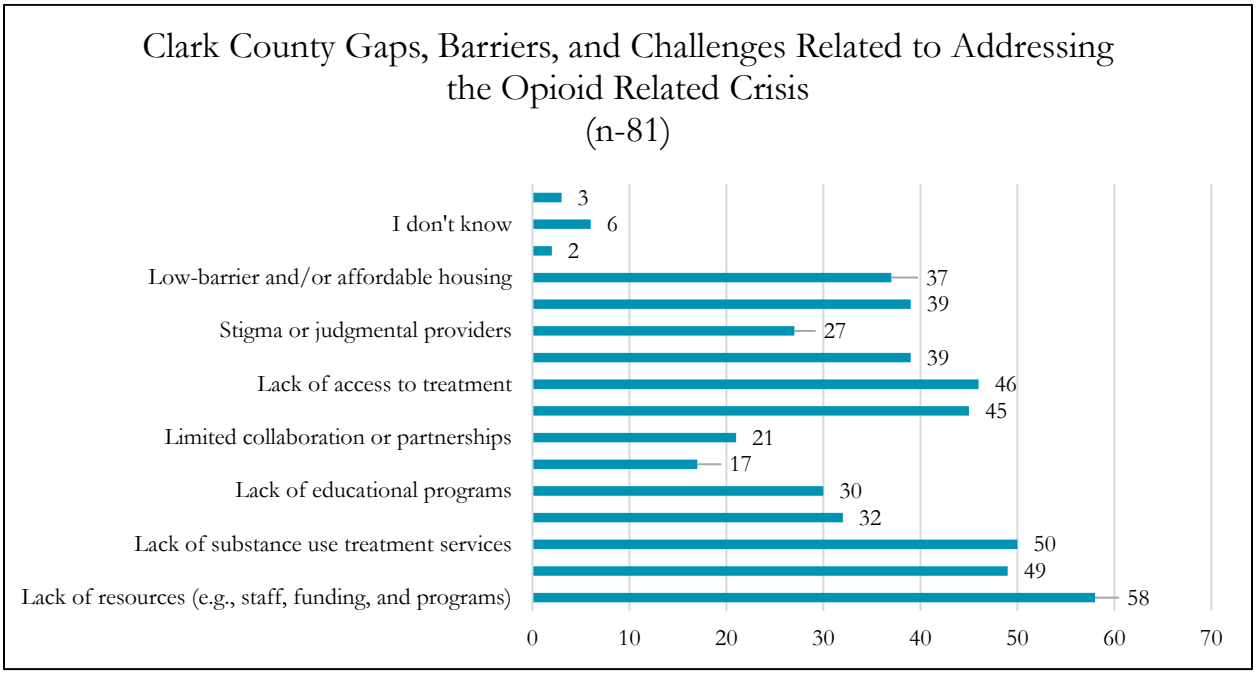


Figure 12: Clark County Gaps, Barriers, and Challenges Related to Addressing the Opioid Related Crisis

At the end of the survey, respondents were tasked with selecting at least three (3) funding priorities out of fourteen (14) options. The top five (5) priorities were:

1. Increase prevention programming in schools.
2. Increase services that address underlying trauma.
3. Increase access to low-barrier substance use treatment services
4. Create specialized programs for parents with opioid use who have child welfare involvement.
5. Increase recovery housing options.

Figure 13 provides a graphical overview of the task that respondents were given- selecting at least three (3) funding priorities out of the fourteen (14) options. Table 4 shows the selection of the top funding priorities by respondent identity. Note, respondents were allowed to select more than one priority on the survey.

(Continues on the next page)

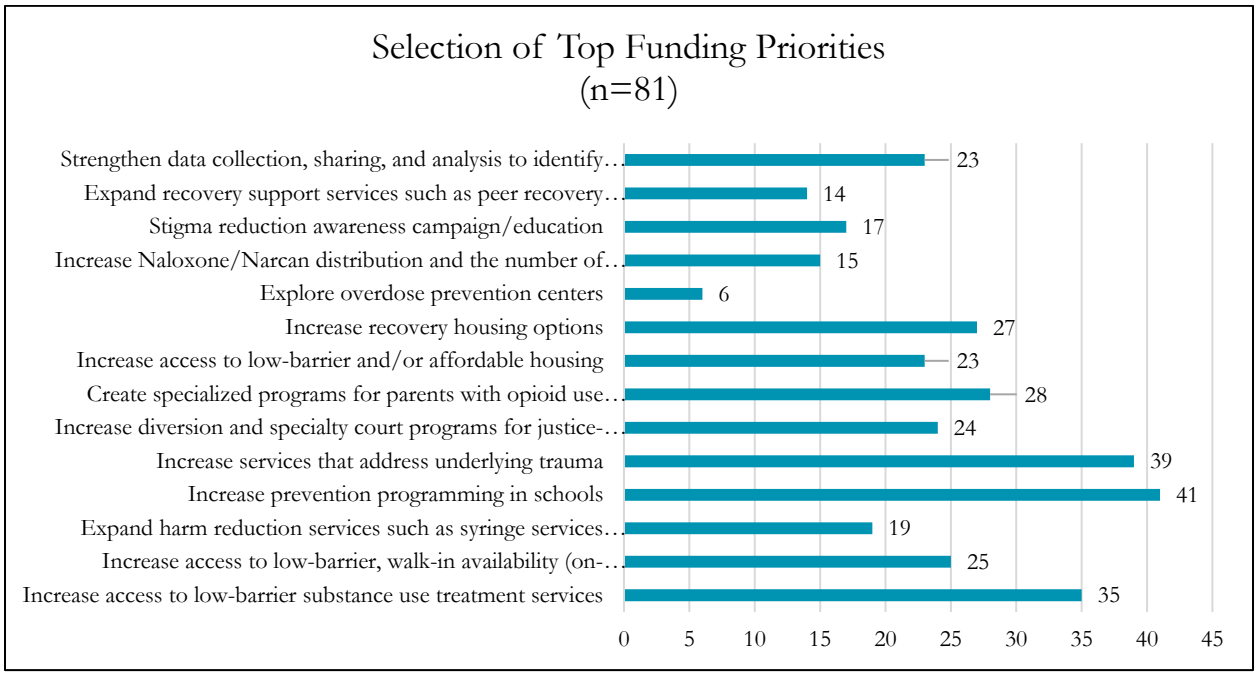


Figure 13: Selection of Top Funding Priorities

(Continues on the next page)

Selection of Top Funding Priorities by Respondent Identity				
Local Government Professional	**Family Member of a Person with an Opioid Use Disorder**	**Child Welfare Agency**	**Law Enforcement**	**Person in Recovery from Opioid Use Disorder[7]**
Increase services that address underlying trauma. (20) Increase prevention programming in schools. (20) Increase access to low-barrier substance use treatment services. (17) Increase access to low-barrier and/or affordable housing. (16) Create specialized programs for parents with opioid use disorder who have child welfare involvement. (14)	Create specialized programs for parents with opioid use disorder who have child welfare involvement. (7) Increase access to low-barrier substance use treatment services. (6) Increase access to low-barrier, walk-in availability (on-demand) of medication-assisted treatment. (5) Increase services that address underlying trauma. (4) Increase access to low-barrier and/or affordable housing options. (4) Increase recovery housing option. (4) Strengthen data collection, sharing, and analysis to identify opportunities for intervention (4).	Increase access to low-barrier substance use treatment services. (12) Increase services that address underlying trauma. (12) Create specialized programs for parents with opioid use disorder who have child welfare involvement. (11) Increase access to low-barrier, walk-in availability (on demand0 of medication-assisted treatment. (9) Increase prevention programming in schools. (9) Increase access to low-barrier and/or affordable housing. (9)	Increase access to low-barrier substance use treatment services. (7) Increase prevention programming in schools. (7) Increase services that address underlying trauma. (6) Create specialized programs for parents with opioid use disorder who have child welfare involvement. (5) Strengthen data collection, sharing, and analysis to identify opportunities for intervention. (5)	Increase access to low-barrier, walk-in availability (on-demand) of medication-assisted treatment. (2) Expand recovery support services such as peer recovery support services. (2)

Table 4: Selection of Top Funding Priorities by Respondent Identity

There was an open-ended question at the end of the survey that allowed respondents to provide other ideas for solving the opioid crisis in Clark County. The question asked respondents to list ideas, without worrying about resources and time. Thirty-eight (38) responses were received. The responses are available in Appendix 2.

[7] Note: Due to the limited number of respondents that identified as persons in recovery from opioid use disorder, all other funding priorities received one vote or no votes.

Southern Nevada Health District Stakeholder and Community Engagement Surveys

Purpose

The Nevada Institute for Children's Research and Policy (NICRP), in collaboration with SNHD conducted the current needs assessment to better understand the barriers to overdose prevention in Clark County and to provide recommendations for addressing the contributors to overdose. Portions of the methodology and results of the survey are presented in this section. A full copy of this report can be found in the Appendix 3.

Methodology

Identification of Assessment Priorities

In November 2023, the project team, composed of 21 researchers, community partners, and individuals impacted by overdose, was brought together for an in-person meeting to identify the priorities of the community needs assessment; nine (9) project team members were able to attend. During the meeting, the team identified the top five (5) facilitators and barriers/gaps impacting overdose prevention in our community; the lists were then ranked. To include input from all project team members, a follow-up survey to all members presenting them with the barriers/gaps and facilitators and asked them to rank order them.

Twenty (20) team members participated in the survey. The results indicated that the community needs assessment should prioritize examining the systemic barriers that contribute to opioid overdose. These include, lack of transportation, and housing insecurity, funding, and data sharing. The facilitators of overdose prevention include the availability of naloxone, test strips, and drug supply checking. Community partners and people who use drugs were identified as those who should be engaged to learn more about these topics.

Instrument Development

Based on the project team's identified priorities, NICRP conducted a comprehensive review of previous needs assessments and surveys related to overdose prevention to help inform the development of the instruments for the community needs assessment. Two (2) instruments were developed: a 20-item survey for people with lived experience with substance use aimed at understanding barriers to overdose prevention and a 15-question semi-structured telephone interview for to understand the barriers to overdose prevention from the service perspective.

Data Collection

To recruit survey participants, SNHD reached out to the SNHD Linkage to Action (L2A) team and the other project partners responsible for providing direct services through the U.S. Centers for Disease Control and Prevention's (CDC) Overdose Data to Action (ODTA: LOCAL) grant. SNHD coordinated with these partners to visit their locations and have the surveys administered in person,

either during scheduled service hours or at pre-organized events. All sites elected to have their clients complete the paper survey as opposed to the electronic version.

To recruit interview participants, SNHD provided NICRP with contact information for nineteen (19) community partners. NICRP emailed each of the partners inviting them to participate and coordinated a 15-minute phone interview. Upon completion of the interview, participants were asked to identify others who would be interested in participating in the interview, and additional participants were recruited. Threats to bias were addressed through multiple interviewers (external to the SNHD team), a structured interview guide to support a consistent experience across participants, and triangulation through a follow-up meeting with stakeholders to provide feedback on results.

Results

Survey For People With Lived Experience

The survey for people who use drugs had 171 respondents, of which 155 reported lived experience with drug use and were included in the analysis. Demographically, the majority were male (65%), aged 31-50 (60%), and identified as White/Caucasian (41%). Most had a high school diploma or some college education (68%). Financially, 31.6% of respondents indicated they sometimes had enough money to cover expenses in the past year, while 26.5% rarely did.

Harm reduction services were a focal point of the survey, with 43.2% of respondents indicating they had not accessed such services in the past. Narcan/naloxone was the most used service (50%), and drug checking was the service respondents were most interested in learning more about (32%). Most respondents felt comfortable accessing these services and found them easy to access. However, respondents identified a need for better resources, including more accessible housing, improved harm reduction services, and enhanced recovery support.

Familiarity and Interest in Harm Reduction Services in the Community (n = 155)				
	Syringe Exchange	**Test Strips**	**Narcan/ Naloxone**	**Drug Checking**
I use/have used this service	43.9% (68)	34.8% (54)	50.3% (78)	34.2% (53)
I have heard of this service, and I'm interested in learning more about it	12.9% (20)	21.9% (34)	18.7% (29)	17.4% (27)
I have heard of this service, but I'm not interested in learning more about it	13.6% (21)	14.2% (22)	12.9% (20)	11.6% (18)
I have never heard of this service, but I'm interested in learning more about it	5.8% (9)	8.4% (13)	1.9% (3)	14.2% (22)
I have never heard of this service, and I'm not interested in learning more about it	14.2% (22)	13.6% (21)	9.7% (15)	14.2% (22)
Missing	9.7% (15)	7.1% (11)	6.5% (10)	8.4% (13)
TOTAL:	**100% (155)**	**100% (155)**	**100% (155)**	**100% (155)**

Table 5: Familiarity and Interest in Harm Reduction Services in the Community (n=155)

Transportation and housing were significant concerns for respondents. Thirty seven percent (37%) used the bus as their main form of transportation. Participants suggested the provision of bus passes, rideshare vouchers reduced transit fares, provision of paper schedules, clear pricing for riding the bus, and shorter wait times for buses to improve access to services.

Housing stability was a challenge, with 57% describing their situation as unstable and 66% unsatisfied with their current housing. Common barriers included affordability, lack of availability, and housing discrimination.

Figure 14 shows the percent of respondents indicating that each of the following has been a barrier experienced when trying to access housing (n = 155)

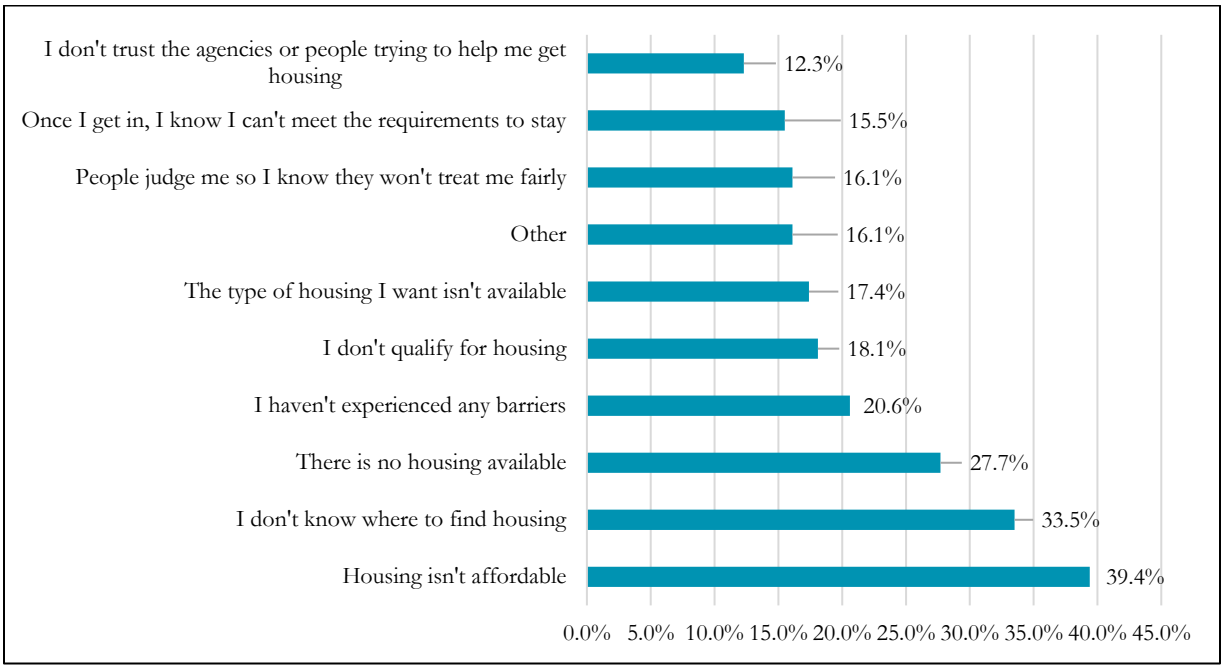


Figure 14: Percent of Respondents Indicating Housing Barriers

Additionally, stigma and discrimination were prevalent among respondents, particularly in interactions with police and healthcare providers, highlighting a need for more supportive and inclusive community services. The most common themes of these responses were doctors being dismissive and not providing them with healthcare services because of their drug use, being treated wrongly or unfairly by police/law enforcement due to prejudice, an overall sense of feeling belittled or shamed in the community and being discriminated against because of their appearance.

Community Partner Interviews

Nineteen (19) respondents provided insights into their demographics and organizational backgrounds. The majority identified as female (68%), aged 25-45 (79%), and White/Caucasian (47%), with 42% having attended some college. Organizationally, most respondents had been with their organizations

for 3-5 years (42%) and worked primarily in harm reduction (21%). The predominant type of organization was non-profit direct service providers (52%).

Respondents rated factors that contributed to overdoses in Clark County. The top contributors identified were an unsafe drug supply (95%), lack of housing (90%), and stigma (90%).

Respondent Ratings of How Much Each Item Listed Contributes to Overdose in the Community (n=19)					
	To a Great Extent	**Somewhat**	**Very Little**	**Not At All**	**Total**
Unsafe drug supply	94.7% (18)	5.3% (1)	0.0% (0)	0.0% (0)	100% (19)
Lack of housing	89.5% (17)	10.5% (2)	0.0% (0)	0.0% (0)	100% (19)
Stigma	89.5% (17)	10.5% (2)	0.0% (0)	0.0% (0)	100% (19)
Lack of funding*	72.2% (13)	22.2% (4)	5.6% (1)	0.0% (0)	100% (18)
Lack of evidence-based primary prevention programs in PreK-12 education*	50.0% (9)	22.2% (4)	27.8% (5)	0.0% (0)	100% (18)
Lack of transportation	42.1% (8)	42.1% (8)	10.5% (2)	5.3% (1)	100% (19)
Insufficient access to harm reduction services	42.1% (8)	52.6% (10)	5.3% (1)	0.0% (0)	100% (19)
Poor care coordination between service providers	36.8% (7)	47.4% (9)	10.5% (2)	5.3% (1)	100% (19)
Lack of data sharing	31.6% (6)	31.6% (6)	31.6% (6)	5.3% (1)	100% (19)
**For these items, n = 18*					

Table 6: Respondent Ratings of How Much Each Item Contributes to Overdose in the Community

Funding was a significant concern, with most organizations being self-supported through grants (33%) and finding it difficult or very difficult to access necessary funding (87%). More than half of the respondents had applied for overdose and harm reduction funding in the past five years, but competition and stigma around harm reduction work posed significant barriers to securing funds.

Regarding data and data sharing, respondents expressed a need for more disaggregated overdose data, real-time data, and information about specific substances and their locations in the community. Additionally, stigma was highlighted, with respondents noting that stigmatizing language was more frequently used by other agencies (90%) compared to their co-workers (17%). Most respondents reported they rarely engaged in or tolerated such language and often spoke up against it (95%).

Recommendations

After analyzing the data, NICRP convened a meeting with the project team to discuss the results, surprising findings, and potential recommendations to address barriers to overdose prevention. Key recommendations include engaging service providers and the community in non-stigmatizing language training, prioritizing stigma reduction training for health care and law enforcement professionals and implementing public awareness campaigns about substance use and overdose. Funding should be

increased to extend service hours and create more access points. Agencies should adopt flexible work schedules to facilitate service access during evenings and weekends. Addressing housing barriers and increasing awareness of housing options, including developing permanent housing programs, are essential. Safe environments for people who use drugs need to be identified, and greater awareness of harm reduction services like drug supply testing and test strips should be promoted. Additionally, service providers should offer bus schedules and advocate for affordable bus fares.

Summary

This assessment highlights critical next steps for addressing overdose in Clark County. Persistent barriers, such as stigma, lack of safe and stable housing, and limited access to resources during non-traditional hours, were identified. Interviews with community partners revealed the need for increased funding and additional training to address self-stigma and provide inclusive spaces. These findings support the development of targeted interventions and strategies to address community gaps and barriers. The ongoing engagement of community partners and those impacted by overdose is crucial for implementing evidence-based solutions. Ensuring successful initiatives will require collaboration, communication, and a commitment to inclusivity, ultimately aiming to reduce overdose and enhance community well-being.

[This page left blank intentionally.]

Impact of Opioid Use/Misuse in Clark County

Opioid Overdose Death Rate Overview

From 2018 to 2023, the age adjusted overdose death rate involving any opioid per 100,000 Clark County residents saw a notable increase of 82.19% largely driven by a surge in fentanyl-related fatalities, which increased by 544.68% during this period. Conversely, the age adjusted overdose death rate involving heroin decreased by 45.34% during the same period. Additionally, there was a notable decline of 37.5% in the age adjusted overdose death rate involving prescription opioids over the same timeframe. These trends underscore the complex landscape of opioid-related fatalities in Clark County, with alarming increases in fentanyl deaths alongside encouraging reductions in heroin and prescription opioid fatalities. (Southern Nevada Health District, 2023)

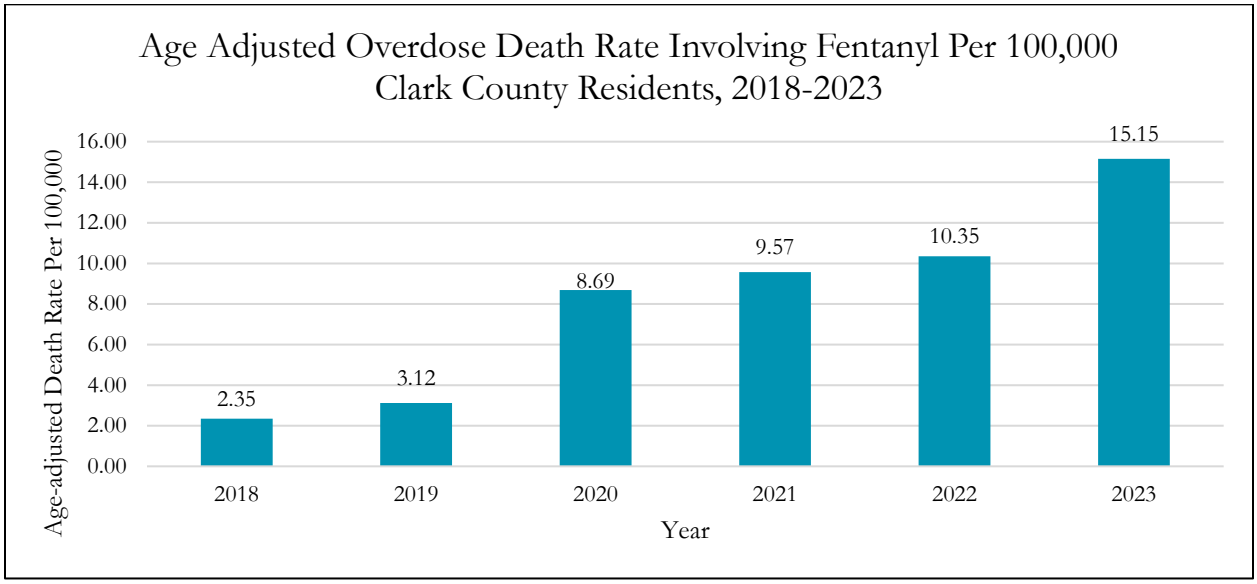


Figure 15: Age adjusted Overdose Death Rate Involving Fentanyl Per 100,000 Clark County Residents, 2018-2023
Source: (Southern Nevada Health District, 2023)

Opioid Overdose Death Geography

Certain regions within Clark County face an elevated risk of opioid overdose fatalities. The top five (5) zip codes exhibiting the highest opioid overdose death rates in 2023 are 89101, 89145, 89169, 89104, and 89119. Additionally, certain regions within Clark County, such as Downtown Las Vegas, Washington & H St, and the University of Nevada, Las Vegas (UNLV) area, showed notable clusters of overdose fatalities by resident location. However, other areas within Clark County, including 13th & Stewart, the Naked City/Arts District area, and the UNLV area, also showed notable clusters of overdose fatalities by overdose location. (Southern Nevada Health District, 2023)

Understanding the geographic distribution of opioid overdose fatalities within Clark County is essential for targeted intervention and prevention efforts. By identifying high-risk areas such as specific zip codes and neighborhoods, public health initiatives can be tailored to address the unique challenges faced by these communities. Moreover, recognizing the evolving patterns of overdose clusters by both

resident and overdose locations underscores the need for comprehensive strategies that encompass education, outreach, and access to treatment and support services.

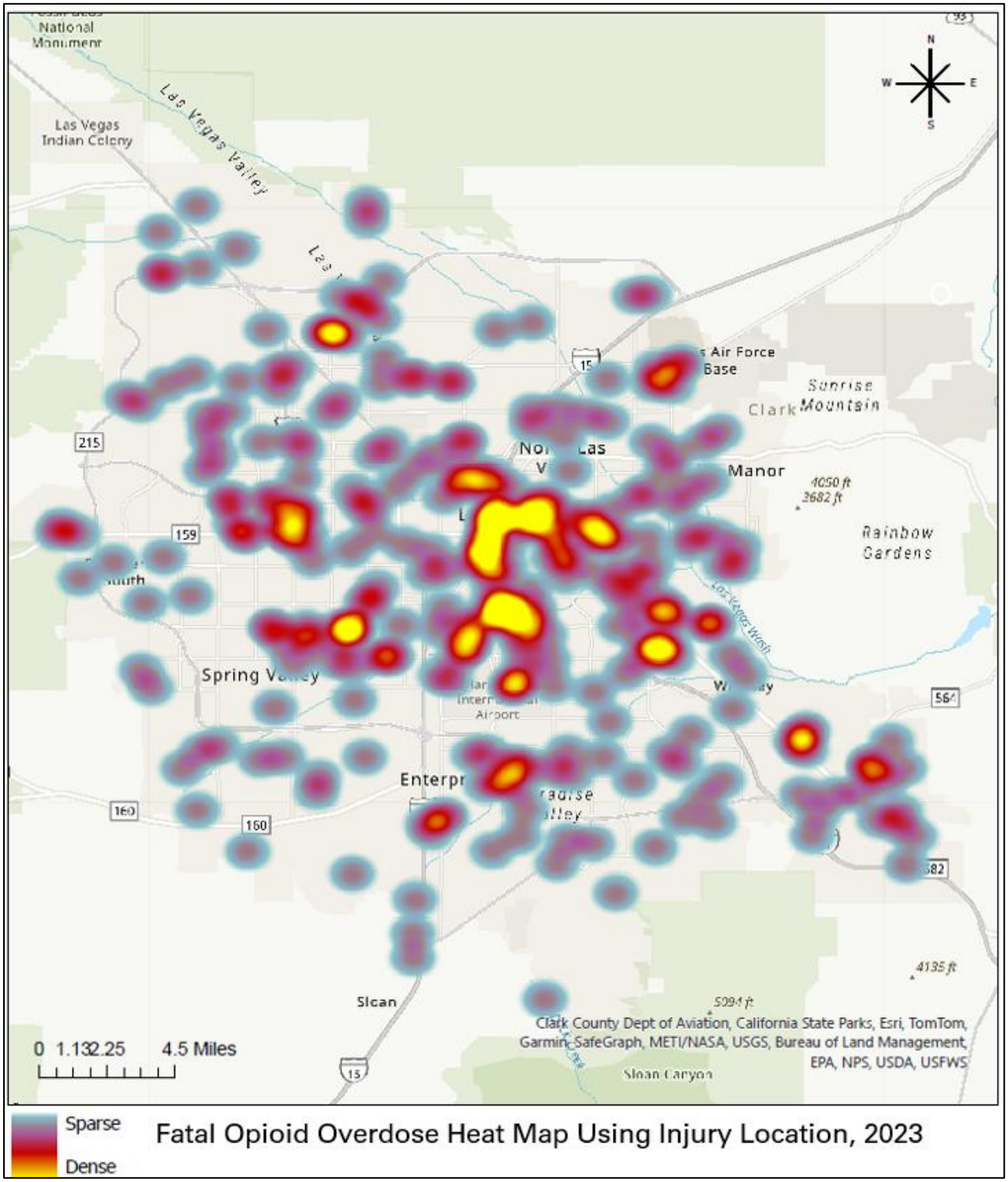


Figure 16: Fatal Opioid Overdose Heat Map Using Injury Location, 2023
Source: (Southern Nevada Health District, 2023)

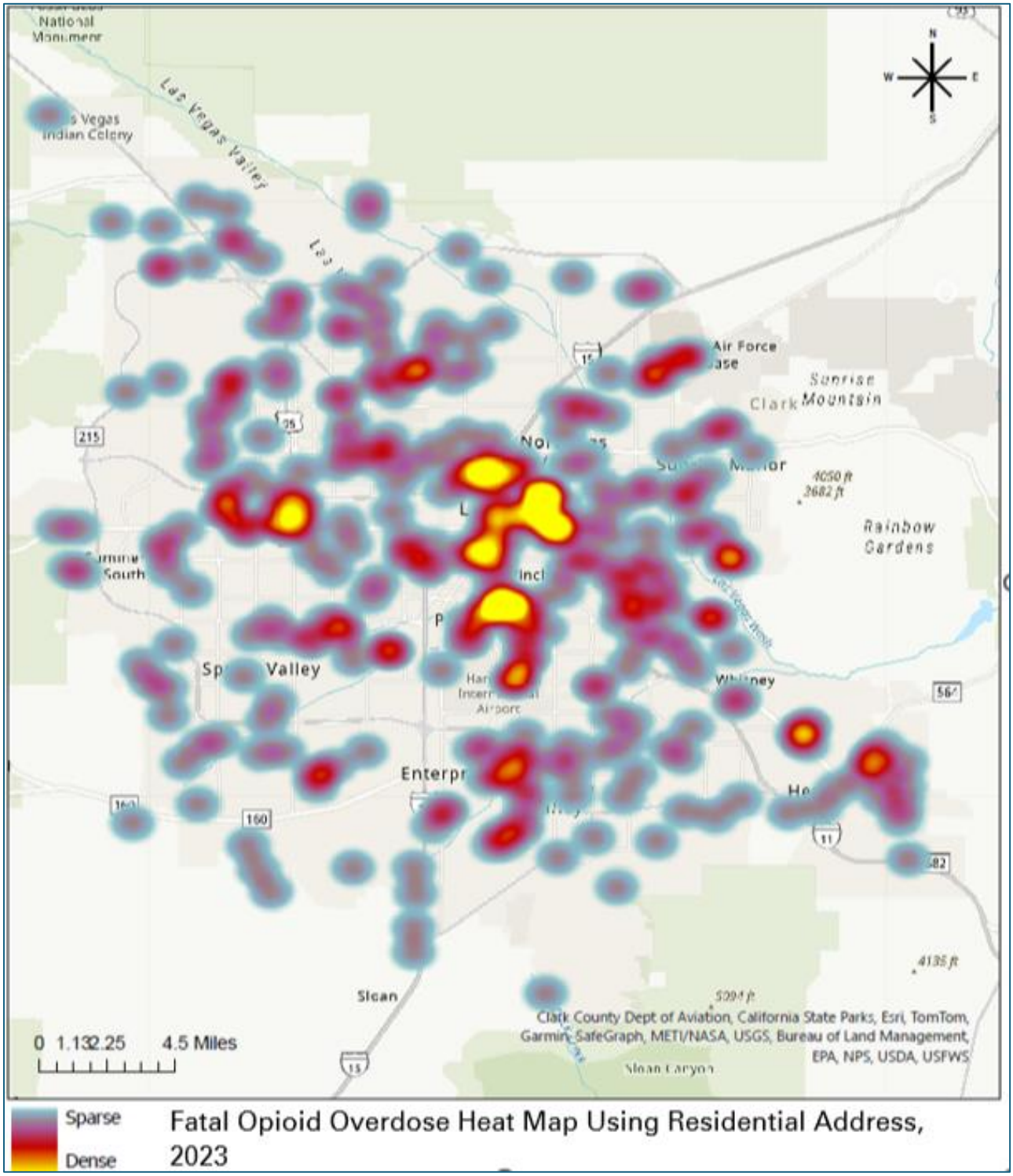


Figure 17: Fatal Opioid Overdose Heat Map Using Residential Address, 2023
Source: (Southern Nevada Health District, 2023)

Polysubstance Overdose Death Trends

Polysubstance overdose deaths, particularly those involving both methamphetamine and fentanyl, are increasingly prevalent. The proportion of fatal fentanyl overdose cases co-occurring with methamphetamine and/or cocaine has been on a consistent rise annually from 2017 to 2023. By 2023, stimulants were involved in 55% of fatal fentanyl overdoses. This emerging trend underscores the imperative to enhance public education and intensify prevention initiatives to address the evolving challenges in substance use. (Southern Nevada Health District, 2023)

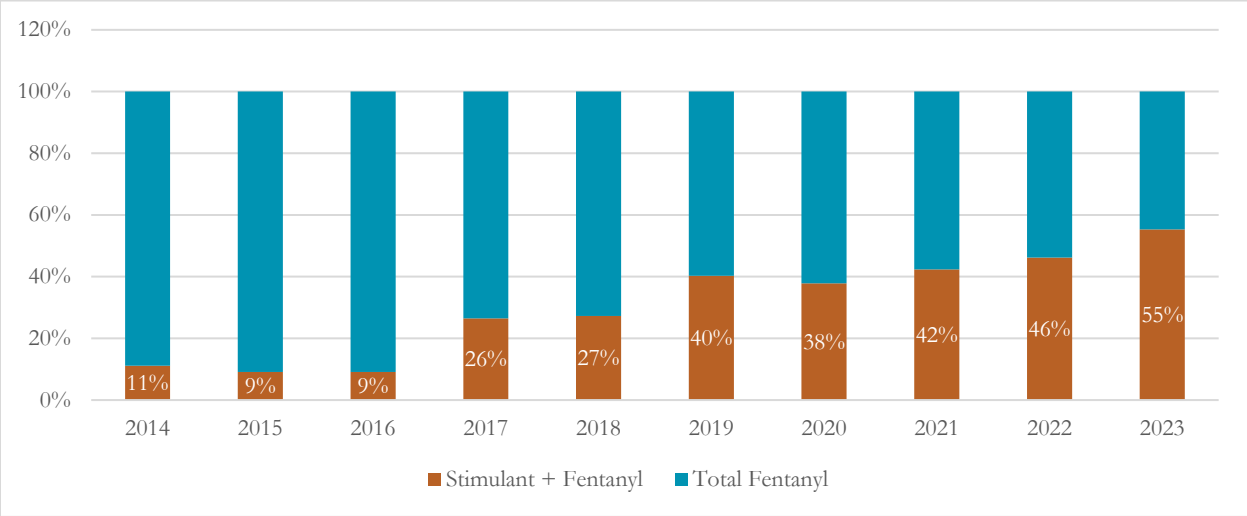


Figure 18: Proportion of Fentanyl Overdose Deaths Co-occurring with Stimulants by Year, Clark County Residents, 2014-2023
Source: (Southern Nevada Health District, 2023)

Opioid Overdose Death Descriptive Statistics

Among racial and ethnic groups, individuals who are Black have the highest opioid overdose death rate, closely followed by those who are White (27.04 and 25.64, respectively). Additionally, men exhibit the highest opioid overdose death rate, which stands at 28.6. The demographic most affected by opioid overdose fatalities is the 35–39 age group and the primary locations for fatal opioid overdose incidents are homes, followed by outdoors/public areas. A comparative analysis between 2022 and 2023 indicates shifts in fatal overdoses. Notably, there was a notable increase in fentanyl-related overdose deaths among age groups 60 to 64 years old, 50 to 54 years old, and 45 to 49 years old. Conversely, female overdose fatalities decreased across all categories of opioids, fentanyl, and methamphetamine. Particularly significant was the marked decline in female overdose deaths involving all categories of opioids (19.53%) and methamphetamine (25.29%). This observed trend could imply the existence of potential gender-specific patterns or the effectiveness of interventions aimed at women.

A logistic regression analysis reveals odds ratios for opioid overdose deaths in calendar year 2023, examining demographic characteristics for independent associations. The findings indicate that Non-White individuals had 43.8% lower odds of fatal opioid overdose compared to White individuals. Additionally, each 10-year increase in age was associated with a significant decrease in the likelihood of opioid overdose death. Females exhibited 39.1% lower odds of fatal opioid overdose compared to males, while individuals who were not married had 83.5% higher odds compared to those who were married. (Southern Nevada Health District, 2023)

Odds Ratio Estimates for Fatal Overdose

Covariate	N	Odds Ratio	95% Confidence Limits		P Value
Age (unit=10 years)	17,530	<0.00	<0.00		<.0001**
		1	1	<0.001	*
Sex					
Male	9,853	(Ref)	(Ref)	(Ref)	(Ref)
Female	8,051	0.609	0.475	0.777	<.0001**
					*
Employment Status					
Employed	17,083	(Ref)	(Ref)	(Ref)	(Ref)
Not Employed	823	0.202	0.114	0.336	<.0001**
					*
Race					
White	13,512	(Ref)	(Ref)	(Ref)	(Ref)
Non-White	4,394	0.562	0.427	0.73	<.0001**
					*
Marital Status					
Married	6,427	(Ref)	(Ref)	(Ref)	(Ref)
Not Married	11,479	1.835	1.376	2.482	<.0001**
					*
Education					
High School Graduate, GED, or Less School	10,255	1.043	0.819	1.335	.7327
Some College or College Degree (e.g., Associates, Bachelors)	7,651	(Ref)	(Ref)	(Ref)	(Ref)

The estimate for the age variable contains the odds ratio for every change of 10 years.
The White race variable includes both Hispanic White and non-Hispanic White
*p<.05, ** p<.01, *** p<.001

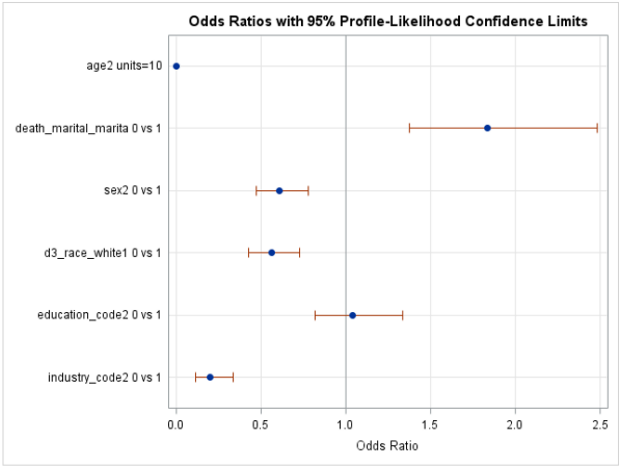


Figure 19: Odd Ratio estimates for Fatal Overdose
Source: (Southern Nevada Health District, 2023)

Fatal Opioid Overdose Time & Day

An analysis of opioid overdose mortality among Clark County residents in 2023 reveals distinct patterns by hour and day. Notably, Sunday and Saturday exhibit the highest daily frequencies of opioid overdose deaths. In contrast, Tuesday recorders the lowest number of opioid overdose fatalities. Interestingly, the day and hour with the highest count of opioid overdose fatalities coincide on both Saturday and Sunday at 2:00 P.M. It is essential to recognize that there may be a significant time lapse before an individual is officially pronounced deceased. (Southern Nevada Health District, 2023)

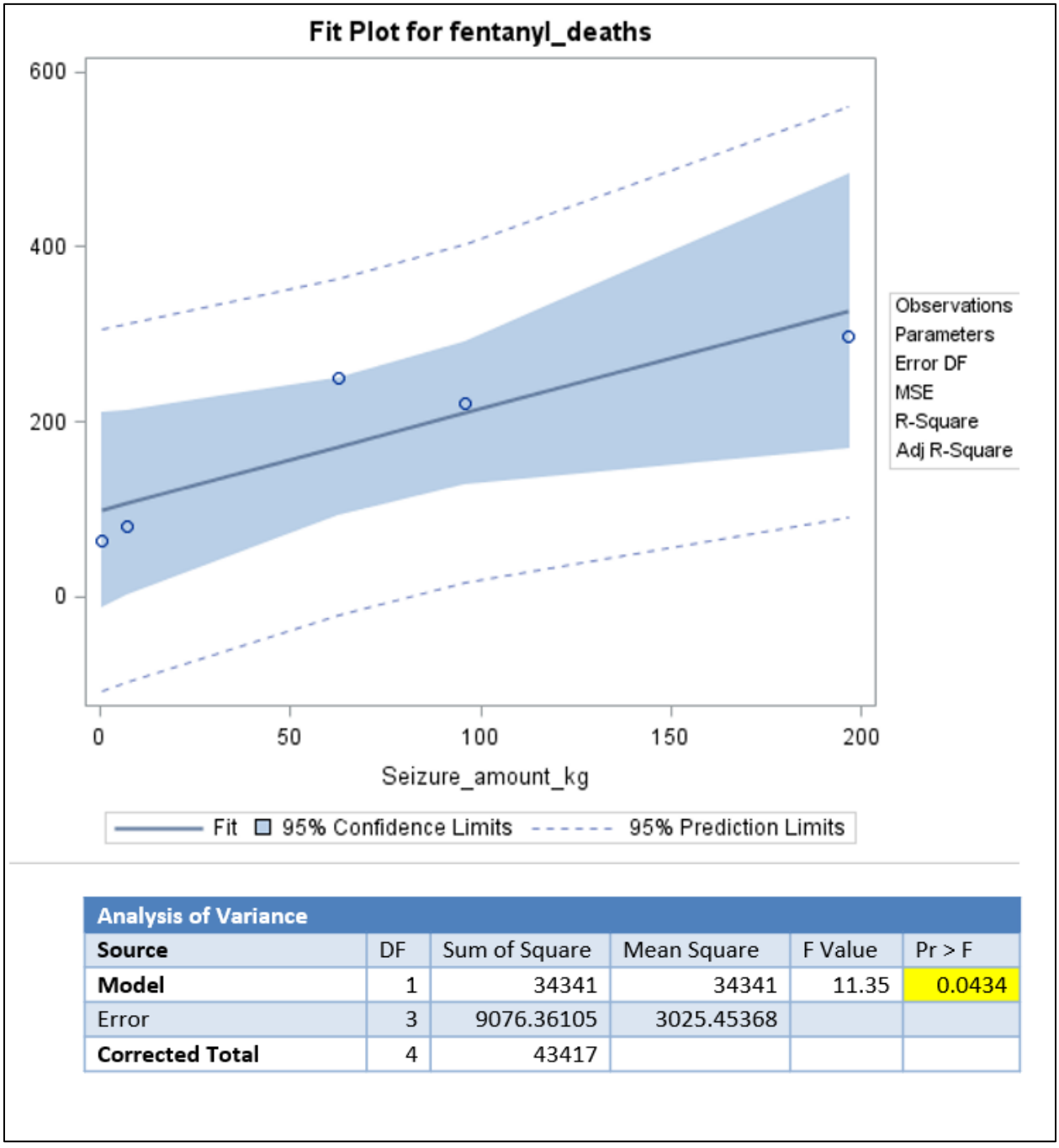
(Continues on the next page)

Figure 20: Opioid Overdose Mortality by Hour and Day
Source: (Southern Nevada Health District, 2023)

Fentanyl Seizure and Fentanyl Death Association

An analysis specifically examined fentanyl deaths and Nevada High Intensity Drug Trafficking Area (HIDTA) seizures via a linear regression. The analysis indicates a correlation between the number of fentanyl seizures and fentanyl-related deaths between 2018-2022. This suggests a significant association between the two variables, implying that changes in one may inform changes in the other. However, while seizures may contribute to variations in fentanyl-related deaths, further research and consideration of additional factors are necessary to fully understand this relationship. (Southern

Nevada Health District, 2023) (Office of National Drug Control Policy, Executive Office of the President, The White House, 2024)



Analysis of Variance					
Source	DF	Sum of Square	Mean Square	F Value	Pr > F
Model	1	34341	34341	11.35	0.0434
Error	3	9076.36105	3025.45368		
Corrected Total	4	43417			

Figure 21: Fentanyl Seizure and Fentanyl Death Association
Source: (Southern Nevada Health District, 2023) (Office of National Drug Control Policy, Executive Office of the President, The White House, 2024)

Non-Fatal Opioid Overdose Descriptive Statistics

Among racial and ethnic groups, the highest non-fatal opioid overdose rates were observed among residents of the City of Las Vegas, in contrast to other cities and the unincorporated area within Clark County as well as men and individuals who are American Indian/Alaskan Native. Odds ratios for non-fatal opioid overdoses were calculated through a logistic regression analysis. The analysis examined demographic characteristics to determine which remained independently linked to non-fatal opioid overdose. After running the logistic regression, it was found that compared to men, women have odds of non-fatal opioid overdose that are 61.4% lower. Additionally, individuals residing outside the city of Las Vegas (such as in Henderson, North Las Vegas, etc.) exhibit odds of non-fatal opioid overdose that are 50.9% lower, while holding all other variables constant. (Southern Nevada Health District, 2024)

Non-Fatal Opioid Overdose Time & Day

An analysis of non-fatal opioid overdoses among Clark County residents in 2023 reveals distinct patterns by hour and day. Notably, Tuesday has the highest frequency of non-fatal opioid overdoses. The hour with the highest number of non-fatal opioid overdoses throughout the week is 3:00 PM. Conversely, Sunday exhibits the lowest occurrence of non-fatal opioid overdoses. (Southern Nevada Health District, 2024)

Non-Fatal Opioid Overdose Geography

In 2023, an examination of non-fatal opioid overdoses using injury location reveals patterns among both Clark County residents and non-residents. Concentrated clusters of overdoses are identified Downtown Las Vegas, Rainbow Boulevard and Charleston Boulevard, Naked City, and Boulder Highway areas. Recognizing the spatial distribution of non-fatal opioid overdoses within Clark County is important for implementing focused intervention and prevention strategies. By pinpointing high-risk zones like these geographic hot spots, public health initiatives can be tailored to tackle the specific issues confronting these communities. (Southern Nevada Health District, 2024)

(Continues on the next page)

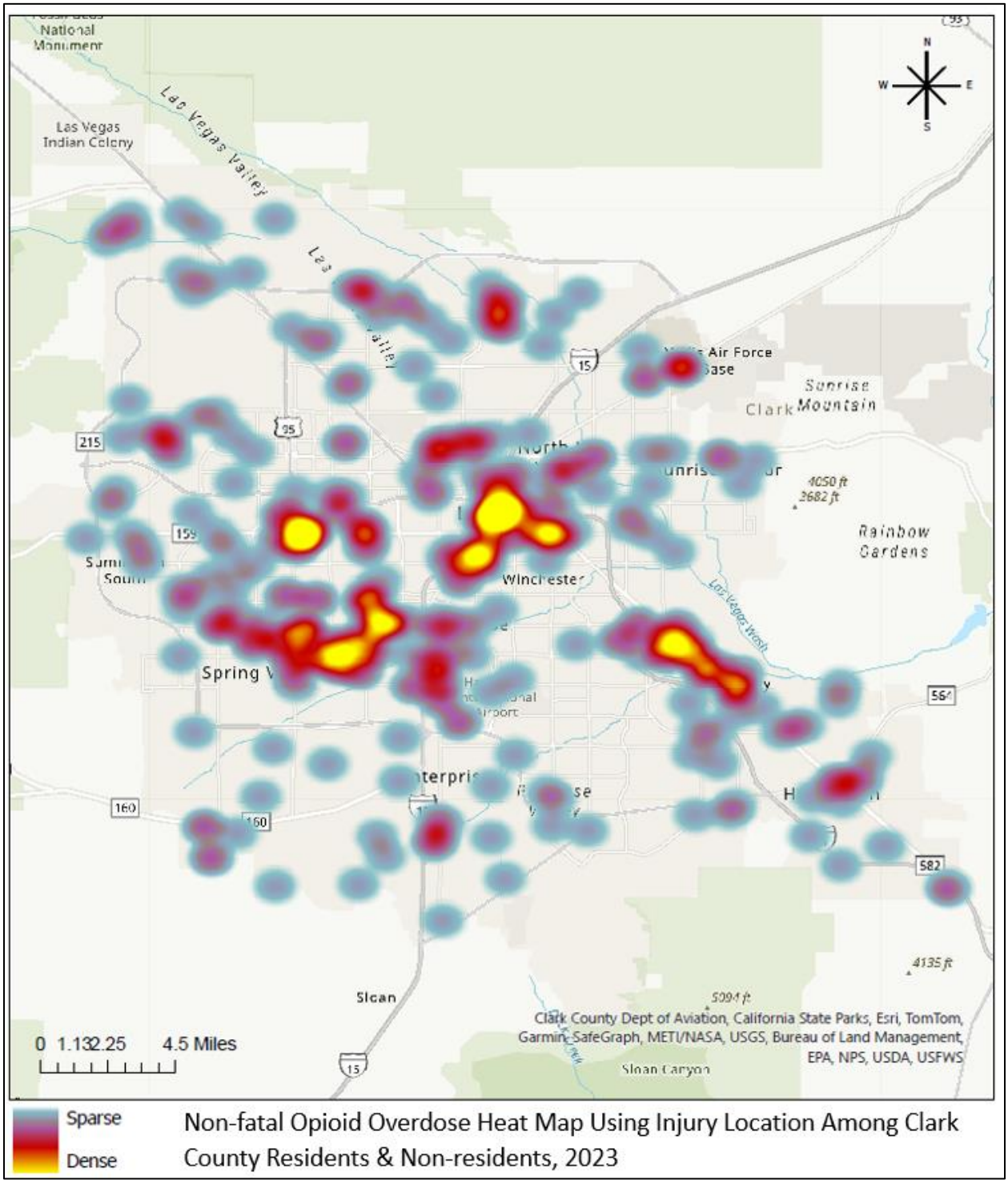


Figure 22: Non-Fatal Opioid Overdose Heat Map Using Injury Location Among Clark County Residents & Non-Residents, 2023
Source: (Southern Nevada Health District, 2024)

Social Vulnerability Index with Opioid Overdose Data

The CDC developed a Social Vulnerability Index (SVI) indicator, which assesses Census Tracts based on 16 social factors such as unemployment, racial and ethnic minority status, and disability. These factors are quantified into a single statistic ranging from 0 to 1, with higher values indicating greater vulnerability. (Centers for Disease Control and Prevention, 2024) When overlaying SVI data with opioid overdose statistics, focusing on those in the 90th percentile, one Census Tract can be identified. The Census Tract with overdose counts and SVI in the 90th percentile is situated in the area encompassing Charleston Boulevard & Las Vegas Boulevard, extending southward to Sahara Avenue.

Examining the population in the 90th percentile for both opioid overdose mortality and SVI, it is observed that Thursdays consistently exhibit the highest frequency of fatal opioid overdoses throughout the week. Among this population, the demographic group with the highest frequencies of opioid overdose deaths comprises predominantly men, individuals who are White, with a notable proportion of these deaths occurring at home. Additionally, the age group most affected is individuals aged 35-39. (Southern Nevada Health District, 2023) (Centers for Disease Control and Prevention, 2024)

(Continues on the next page)

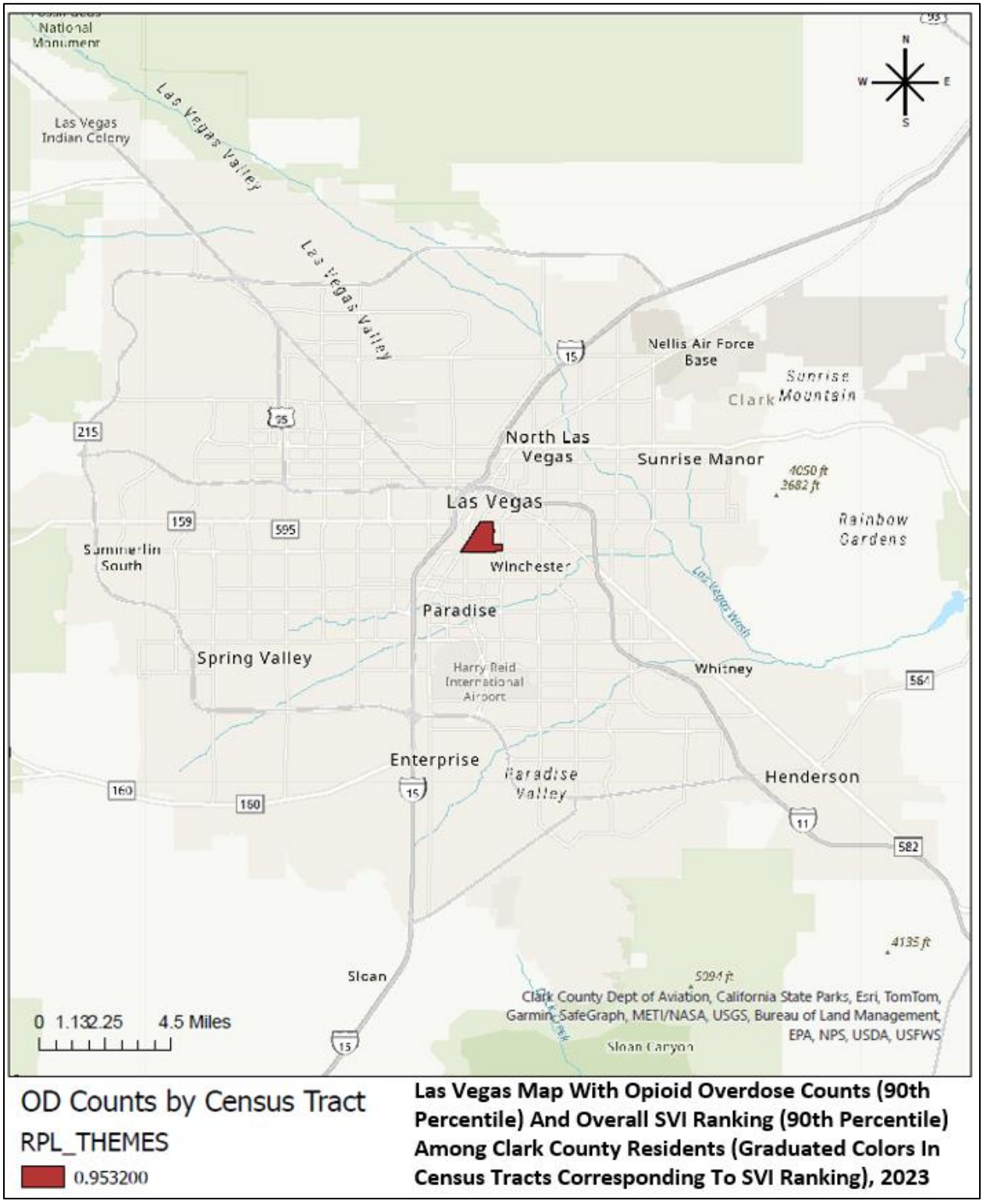


Figure 23: Overdose Counts by Census Tract

Sources: (Southern Nevada Health District, 2023) (Centers for Disease Control and Prevention, 2024)

Wastewater Analysis

An analysis by Gerrity et al. (2024) used sucralose normalization to assess opioid presence across six (6) different sewersheds in Clark County, revealing higher heroin and fentanyl use in sewershed 3 (City of Las Vegas) and elevated levels of other opioids in sewershed 6 (Boulder City), despite some extreme outliers. Sewershed 2, a higher-income area near Sloan Canyon with a large retirement population, showed moderate levels of legal opioids but lower heroin and fentanyl use, highlighting potential targets for public health intervention.

Notably, the detection of norfentanyl increased significantly after October 2022, indicating a rise in fentanyl consumption in Southern Nevada, coinciding with public health advisories and media coverage of fentanyl-related incidents. The study data also showed a substantial increase of approximately 200% in heroin and methamphetamine use since 2010, alongside a sharp rise in fentanyl consumption starting in October 2022. Although wastewater surveillance data is not a direct measure of substance use in a community, it can be used to track trends in substance use over time and to identify areas where there may be a high prevalence of substance use. (Gerrity, et al., 2024) More work is needed to understand the opportunities to use wastewater data to drive public health intervention.

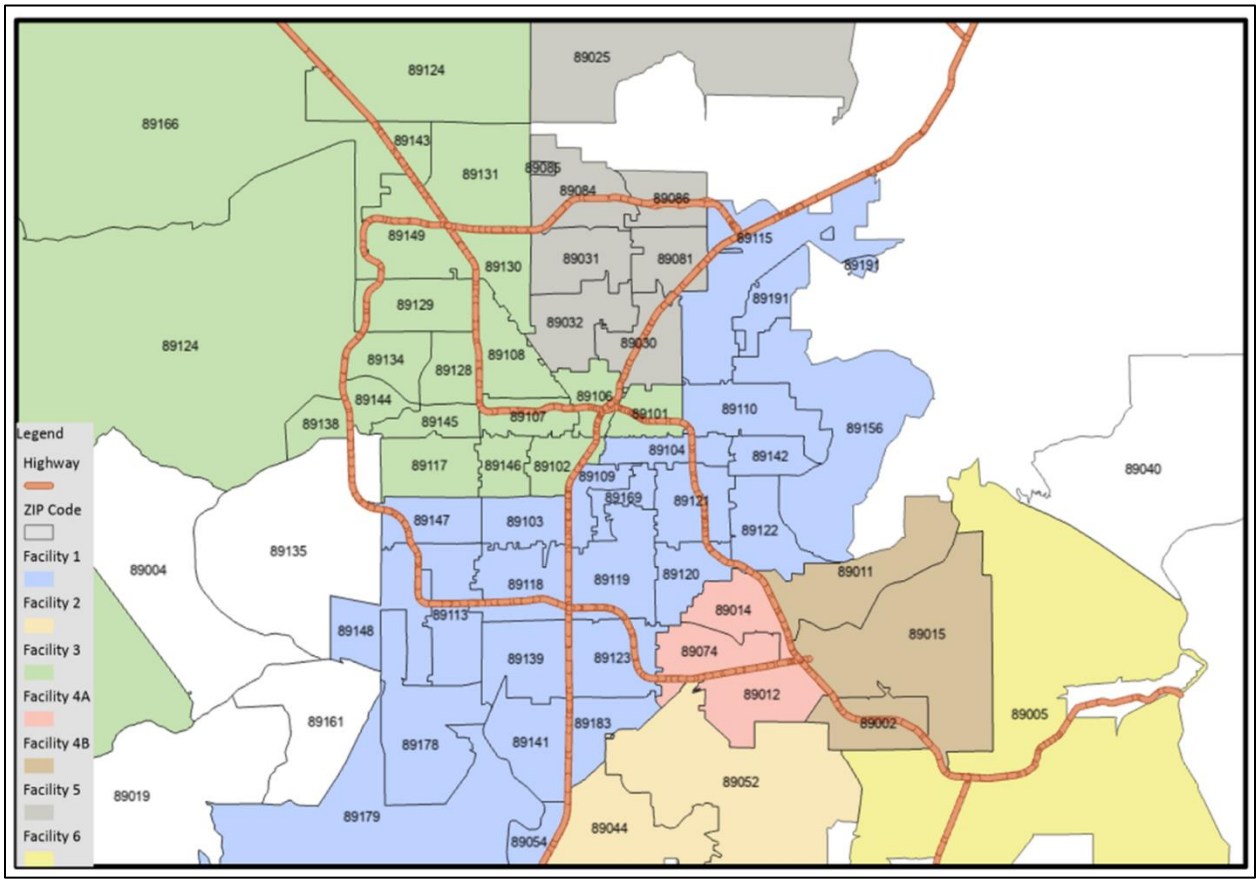


Figure 24: Analysis of Opioid Presence Across Six Different Sewersheds in Clark County
Source: (Gerrity, et al., 2024)

Drug Checking

SNHD has implemented an innovative surveillance program in Clark County, where drug refuse is anonymously collected and analyzed. This drug checking surveillance program aims to rapidly identify substances and respond accordingly. The initiative seeks to enhance understanding of the local illicit drug supply, guiding overdose prevention activities, educational efforts, harm reduction strategies, and care linkage. (Southern Nevada Health District, 2024)

Since its inception in December 2022, the program has collected 502 samples. Analysis of these samples revealed that methamphetamine was present in 53.7% and heroin in 38.9%. Although xylazine use has not been widely reported in Nevada, the program recently detected xylazine.

Samples are collected from various types of refuse to ensure comprehensive representation of substance use in the community. The breakdown of items sampled includes:

- 53.19% syringes
- 10.96% pipes used for smoking

Of the refuse tested, 12.15% mixtures contained fentanyl (among other substances). Of these, 24.59% were heroin mixed with fentanyl, and 57.38% were methamphetamine mixed with fentanyl. Xylazine was identified in 1.0% of sample and all xylazine-positive samples also contained fentanyl.

This program not only highlights the presence of xylazine but also underscores the importance of monitoring emerging drug trends to inform public health responses.

Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) "measures health-related behaviors and experiences that can lead to death and disability among youth and adults." Moreover, "it is a set of surveys that track behaviors that can lead to poor health in students grades 9 through 12." (Centers for Disease Control and Prevention, 2023) Data from the YRBSS is available for the State of Nevada and the United States. Unfortunately, there is no data for the Clark County School District (CCSD) since 2019. Thus, no analysis for high school students at the county level is available.

Since 2017, Nevada students are actively using prescription medicine without a doctor's prescription or differently than prescribed than the entire United States. For Nevada specifically, there was an increasing trend in the usage of the prescription medicine despite small decrease in 2021. This decrease could be attributed to less high school students participants in the YRBSS due to the COVID-19 pandemic.

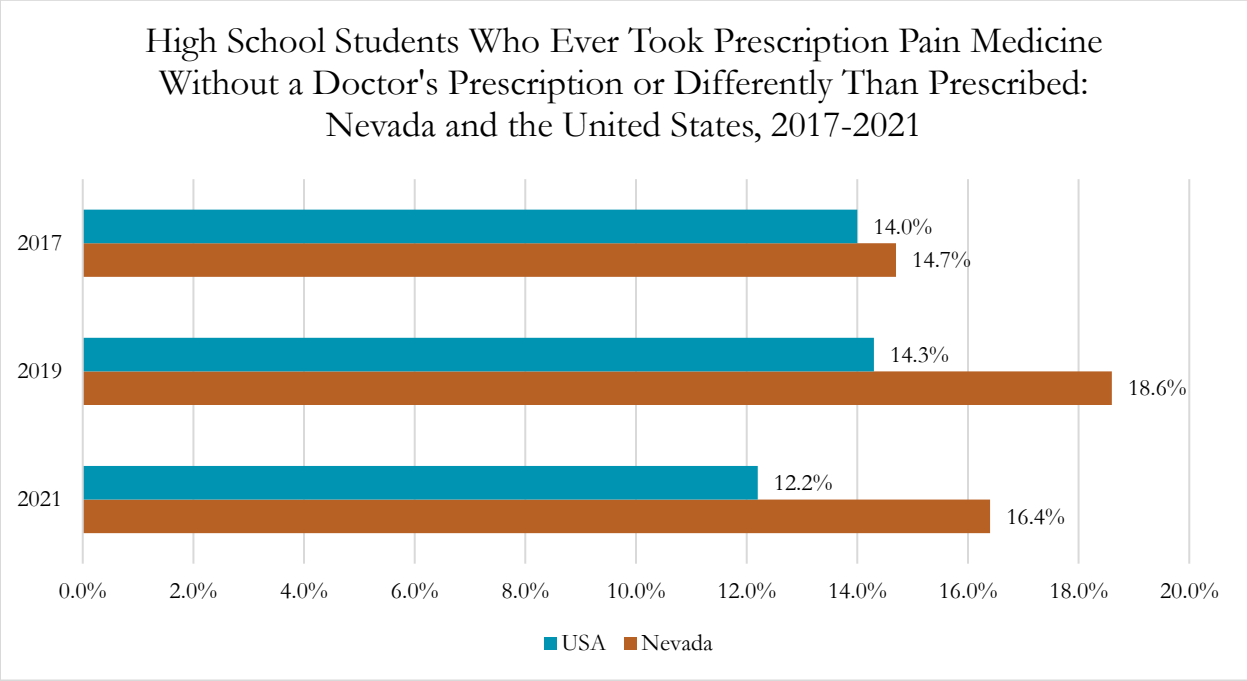


Figure 25: High School Students Who Ever Took Prescription Pain Medicine Without a Doctor's Prescription or Differently Than Prescribed: Nevada and the United States, 2017-2021
Source: (Centers for Disease Control and Prevention, 2023)

Similar to that of the prescription pain medicine usage, Nevada high school students are using heroin more than other students in the United States.

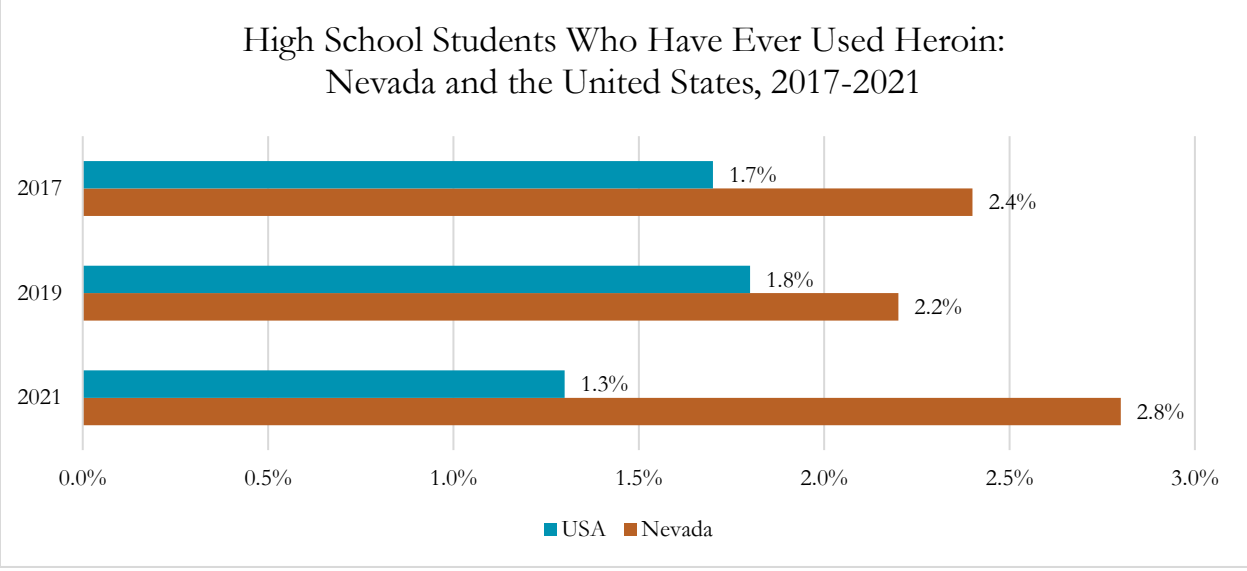


Figure 26: High School Students Who Have Ever Used Heroin: Nevada and the United States, 2017-2021
Source: (Centers for Disease Control and Prevention, 2023)

Juvenile Drug Court Participants

The Clark County Juvenile Drug Treatment Court (JDTC) mission is "to reduce substance use and delinquency rates by Clark County teens." Through therapeutic interventions, judicial supervision, and random drug and alcohol tests, the JDTC works to address alcohol and drug use among teens in the program. The long-term objectives of JDTC are to "improve the mental and physical health of JDTC participants, address the dynamics of participant family units, and increase the community's safety by reducing delinquency rates of participants." (Eighth Judicial District, n.d.)

Data provided by the JDTC for the period of 2019-2023 shows that marijuana is the main drug of choice for JDTC participants (69.5%) with 11.2%, participants reporting alcohol use. For the same period of time, 0.88% of JDTC participants reported using heroin and 1.88% of the participants reported using other opiate drugs. Note, for the purposes of the data, participants could select more than one drug of choice. (Eighth Judicial District Court, 2019-2023)

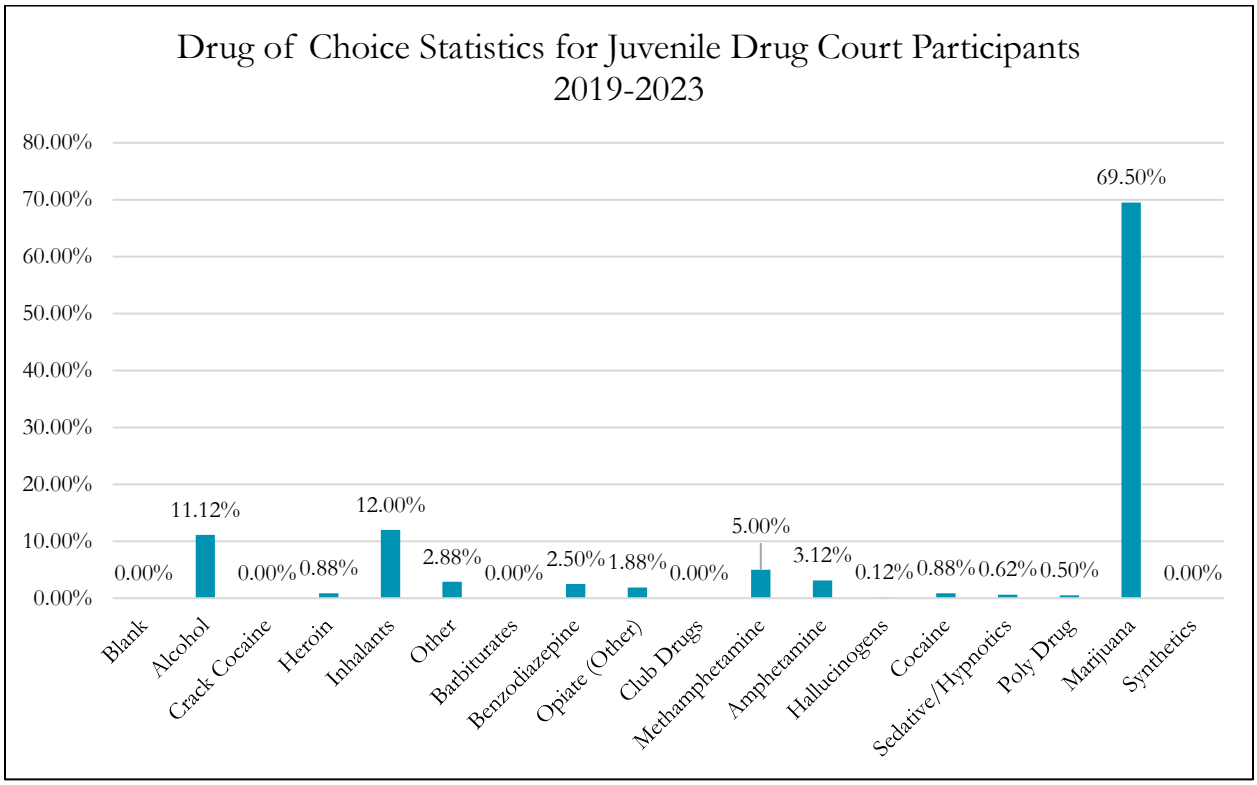


Figure 27: Drug of Choice Statistics for Juvenile Drug Court Participants
Source: (Eighth Judicial District Court, 2019-2023)

(Continues on the next page)

Drug of Choice Statistics for Juvenile Drug Court Participants 2019-2023				
Value	**Frequency**	**Cumulative Frequency**	**Percent**	**Cumulative Percent**
Blank	0	0	0.00%	0.00%
Alcohol	89	89	11.12%	11.12%
Crack Cocaine	0	89	0.00%	11.12%
Heroin	7	96	0.88%	12.00%
Inhalants	1	97	12.00%	12.12%
Other	23	120	2.88%	15.00%
Barbiturates	0	120	0.00%	15.00%
Benzodiazepine	20	140	2.50%	17.50%
Opiate (Other)	15	155	1.88%	19.38%
Club Drugs	0	155	0.00%	19.38%
Methamphetamine	40	195	5.00%	24.38%
Amphetamine	25	220	3.12%	27.50%
Hallucinogens	1	221	0.12%	27.62%
Cocaine	7	228	0.88%	28.50%
Sedative/Hypnotics	5	233	0.62%	29.12%
Poly Drug	4	237	0.50%	29.62%
Marijuana	556	793	69.50%	99.12%
Synthetics	0	800	0.00%	100.00%

Table 7: Drug of Choice Statistics for Juvenile Drug Court Participants, 2019-2023
Source: (Eighth Judicial District Court, 2019-2023)

Clark County Department of Family Services

The Clark County Department of Family Services (DFS) tracked opioid-related referrals from January 1, 2022, to March 31, 2024. During this period, a total of 290 referrals were received: 145 in 2022, 109 in 2023, and 36 in the first quarter of 2024. The majority of these referrals were for investigations, with 142 in 2022, 105 in 2023, and 36 in 2024. (Clark County Department of Family Services, 2024)

Regarding tracking characteristics, there were 157 referrals in 2022, primarily for illicit opioid use and prescription opioid misuse. In 2023, there were 113 referrals, again mostly for illicit opioid use. In 2024, up to March 31, there were 36 referrals, with illicit opioid use being the most common characteristic. (Clark County Department of Family Services, 2024)

DFS has seen a large number of opioid-related referrals, with a notable increase in cases of illicit opioid use. This trend underscores the urgent need for comprehensive public health initiatives to address opioid misuse, enhance community education, and provide greater access to treatment and support services. By targeting these efforts, Clark County can reduce the incidence of opioid misuse and improve the well-being of the Clark County community.

Emergency Services Utilization

Regarding yearly trends in overdose emergency department (ED) visits in Clark County, the data reveals distinct patterns across different drug categories from 2017 to 2021. For overdose ED visits by any drug, there was a consistent decrease observed from 2017 to 2020, followed by a slight increase in 2021. Conversely, opioid-related ED visits showed a general trend of increase from 2017 to 2020, with a slight decrease in 2021. In contrast, methamphetamine-related ED visits exhibited variability with no consistent trend observed over the same period. These trends underscore the complexity of substance use dynamics and highlight the importance of considering various factors such as changes in reporting practices, availability of treatment services, and shifts in drug use patterns when interpreting the data. (Southern Nevada Health District, 2024)

[This page left blank intentionally.]

Community-Based Opioid Use Indicators

Crime Statistics

Between 2021 and 2022, the Las Vegas Metropolitan Police Department (LVMPD) observed a 1.2 percent rise in violent crime alongside a 3.5 percent decline in property crime rates.

In a bid to alleviate the strain on the prison population and mitigate costs for taxpayers, state legislatures enacted Assembly Bill 236 (A.B. 236), effective July 1, 2020. A.B. 236 introduced a tiered penalty system for drug-related offenses based on increasing quantities of controlled substances. Previous legislation did not establish weight thresholds for offenses such as Possession of a Controlled Substance, Possession for the Purpose of Sale, Sale, Manufacture, or Delivery of a Controlled Substance, except for Trafficking a Controlled Substance, which began at 4 grams for Schedule I substances. The revisions under A.B. 236 included provisions for judicial discretion to offer probation instead of incarceration for second and third-time drug offenses and raising the trafficking threshold from 4 grams to under 100 grams for Schedule I and II substances. (Nevada Legislature, 2019)

Per the Nevada Department of Corrections (NDOC), individuals imprisoned for drug-related offenses constituted 7.09 percent of the overall 10,354 inmates in custody as of December 2022. Within the incarcerated population, the majority were convicted for violent offenses, comprising 50.21 percent, with sex offenses following at 18.0 percent and property crimes at 12.7 percent. (Office of National Drug Control Policy, Executive Office of the President, The White House, 2024)

Drug Availability

The Nevada HIDTA has conducted a thorough assessment and asserts with high confidence that fentanyl and its associated counterfeit pills pose a significant drug threat. This determination is based on several factors, including the sustained rise in availability, seizure data, the high demand for fentanyl-laced pills, and the alarming increase in fentanyl-related overdose deaths. The Nevada HIDTA indicate that fentanyl has emerged as Nevada's most pressing threat, surpassing Methamphetamine. Furthermore, Nevada has witnessed a notable surge in fentanyl-related overdose deaths, along with a staggering 213 percent increase in fentanyl-related seizures in 2022 compared to the previous year. Nevada HIDTA has seen the introduction of various new forms of fentanyl. It is anticipated that fentanyl will remain a significant threat in Nevada, with continued availability and the likelihood of overdose-related deaths persisting. (Office of National Drug Control Policy, Executive Office of the President, The White House, 2024)

Opioid Prescribing

The national opioid dispensing rate experienced a continuous decrease, starting at 46.8 opioid prescriptions dispensed per 100 persons in 2019 and dropping to 39.5 opioid prescriptions dispensed per 100 persons in 2022. This totals more than 131 million opioid prescriptions. The Clark County opioid prescribing rate has been steadily decreasing since peaking in 2011, but it remains above the national average. In 2019, the rate was 49.2, which decreased to 48.3 in 2020 and further to 45.8 in

2021, with the most recent data for 2022 showing a rate of 41.5 per 100 persons. It's worth noting that Clark County's rate of 41.5 opioid prescriptions dispensed per 100 persons in 2022 is higher compared to Maricopa County, Arizona (39.3), San Diego County, California (23.2), and San Bernardino County, California (29.4); all nearby counties that are comparable to Clark County. Beyond opioids, stimulants, specifically methamphetamines, remain a significant threat to public health and overdose prevention initiatives. (U.S. Centers for Disease Control and Prevention, 2024)

[This page left blank intentionally.]

Local Promising Programs

Below, this report highlights some local programs and practices that are currently being implemented that show promise at reducing opioid overdose. The highlights included herein are not exhaustive.

Targeted Naloxone Saturation

Clark County's opioid overdoses are driven primarily by fentanyl, prescription opioids, and heroin (Southern Nevada Health District, 2023). One evidence-based policy response to mitigate the burden of fatal and non-fatal opioid overdose is to broaden overdose education and naloxone distribution to people at risk of experiencing or witnessing an opioid overdose.

The Nevada Division of Public and Behavioral Health set the target of having naloxone used in 80% of witnessed overdoses which was based upon the model developed by Irvine et. al. (2022). (Irvine, 2022) The Irvine model used counterfactual modeling to project the effect of increased naloxone distribution on the estimated number of opioid overdose deaths averted with naloxone and the number of naloxone kits needed to be available for at least 80% of witnessed opioid overdoses by US state. It is important to note that the Irvine model was based on 2017 drug overdose data which did not account for the marked increase in opioid overdose mortality beginning in 2020.

Specifically for Nevada, Irvine et. al. (2022) concluded 115,000 two-dose naloxone kits would need to be distributed annually to ensure the probability of having naloxone present at approximately 80% of witnessed overdoses. Irvine et. al. (2022) also concluded that almost all US states have underdeveloped naloxone distribution efforts and that few can avert 80% of witnessed deaths due to opioid overdose with naloxone).

To approximate the local saturation, SNHD took the following approach. Given that Clark County comprises 73% of Nevada's population, to reach saturation Clark County would need to distribute 83,950 two-dose kits annually. The highest yearly quantity of naloxone distributed took place in 2023 due to additional state resources. In 2023, SNHD distributed 15,936 two-dose kits leaving Clark County with a naloxone saturation deficit of 68,014 two-dose kits in 2023. (Office of Informatics and Epidemiology, Southern Nevada Health District, 2024)

(Continues on the next page)

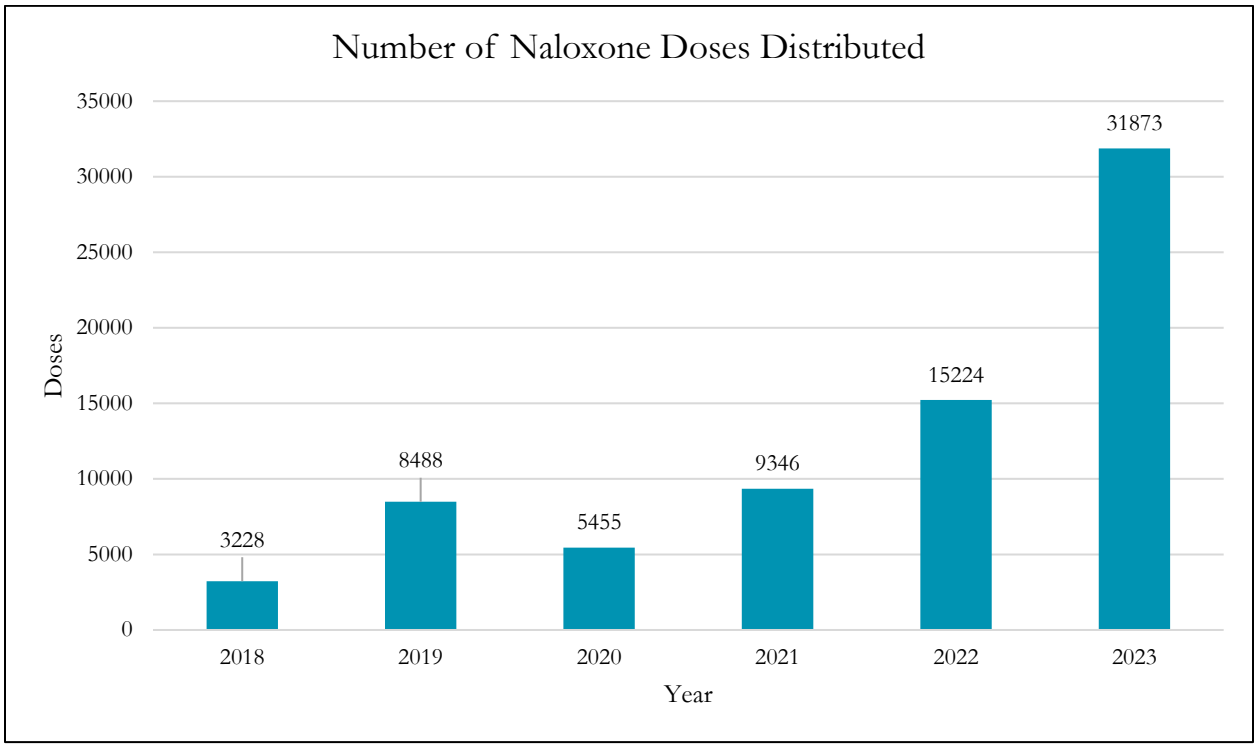


Figure 28: Number of Naloxone Doses Distributed
Source: (Office of Informatics and Epidemiology, Southern Nevada Health District, 2024)

Clark County Detention Center

The Clark County Detention Center (CCDC) is the largest detention facility in the State of Nevada. Between May 2023 through April 2024, there were a total of 58,722 bookings and 58,566 releases at CCDC. The average daily population was 2,931 over the same period with an average length of stay of 19 days.

Medication-assisted treatment (MAT) services were implemented at CCDC in February 2024 and targeted specifically to CCDC's inmate population who participate voluntarily, both pre- and post-release.

Inmates brought to CCDC are seen by on-site, contracted medical staff as part of the standard booking process. As part of the exam, inmate needs are identified to include existence of an opioid use disorder, as well as other pre-existing medical conditions. Inmates who admit to the use of opioids or other controlled substances are further assessed by the staff focused on medication-assisted treatment (MAT).

The MAT staff performs the Clinical Opioid Withdrawal Scale (COWS) Assessment for inmates that admit to recent opioid use or exhibit signs of being under the influence of an opioid. The COWS Assessment is a nationally recognized tool to ascertain the immediate needs of the patient to assist them in safely experiencing the wide range of withdrawal symptoms. Based on the individual score for the COWS Assessment, inmates may be provided with medication to assist with the withdrawal symptoms. The first 8-24 hours after use are the most critical regarding risk to patients. Therefore, inmates in active detoxification are placed into CCDC's medical detoxification module under constant

watch by both medical staff and correctional officers along with the use of a medical monitoring system (medical bracelet) as a complement to visual checks by correctional officers or medical treatment. These complimentary actions reduce the risk of inmates suffering from medical emergencies or attempting suicide during the most difficult physical withdrawal symptoms.

Inmates that admit to opioid use during the booking process are also given the Diagnostic and Statistical Manual of Mental Disorders Assessment (DSM-V) to identify the degree of OUD. The tool assigns a score ranging from 0-11 with a score over 2 signifying the existence of an OUD and any score over a 6 classified as a severe OUD. The DSM-V is a nationally recognized tool to assess for a wide range of behaviors and disorders, including neurodevelopmental disorders, schizophrenia and other psychotic disorders, obsessive compulsive disorders, trauma disorders, dissociative disorders, eating disorders, neurocognitive disorders as well as SUDs or OUDs.

Once an inmate is no longer in the acute withdrawal phase, or during the booking process if not currently under the influence, medical staff discusses the MAT program at CCDC and offers the inmate the opportunity to participate.

Inmates that opt into the MAT program are referred to the MAT Program Coordinator who facilitates an in-depth screening to determine if the program is feasible for the inmate. All inmates entering the program must agree to provide a urine sample at the start of their program and every 30 days thereafter up to their release. Additionally, all participants in the MAT program must agree to, and actively participate in, counseling by MAT staff and adhere to the guidelines set forth by the MAT Discharge Planner. The program participants must agree to take all prescribed medication as intended. Currently, the program is available for participation by up to 150 inmates.

Within the first 120 days of MAT programming implementation at CCDC, there were 649 individuals referred to receive MAT services. However, only 396 (61%) were assessed by MAT program staff as the balance were released from custody prior to assessment. Of the 396 assessed, 394 (99%) were recommended for MAT programming, more than double the current program capacity (150 concurrent participants). The current participation level (107) is below the program capacity due to recent releases to NDOC or program removals (subsequent refusals; side effects).

Of the 183 MAT program participants discharged in the first 120 days of services, Behavioral Health Group (BHG)[8] has only received eight (8) individuals post-release to date, two (2) of which were subsequently discharged, and four (4) of which are currently continuing MAT services (via BHG). The primary barriers to the continuation of care have been releases directly to NDOC or an inability to arrange transportation from CCDC to BHG, an issue that should be resolved within the next 30 days.

There have been 20 (11%) MAT program participants who have been released from custody but have since reoffended and been returned to CCDC in the first 120 days of MAT programming implementation. Of those, four (4) have been placed back into MAT programming (one refused; 15 were subsequently re-released prior to being placed back into the program).

[8] Clark County has contracted with Behavioral Health Group for outpatient therapies and medications to provide continuity of care for CCDC inmate MAT program participants who re-enter the community.

Section Source: (Clark County Detention Center, 2024)

Clark County Regional Opioid Task Force

The Clark County Regional Opioid Task Force (Opioid Task Force) was created by Assembly Bill (A.B.) 132 of the 2023 Nevada Legislative Session. The Opioid Task Force is comprised of fifteen members appointed by the Clark County Board of County Commissioners and will expire by limitation on December 31, 2024.

Over a twelve-month period, the Opioid Task Force will review data relating to opioid overdose fatalities and near facilities and use such data to identify gaps in community services relating to opioids and opioid overdose fatalities. Moreover, the Opioid Task Force will review available data from existing state and community database and, in particular, information relating to harm reduction and substance abuse. Finally, the Opioid Task Force will identify trends in the social determinants of health relating to opioid overdose fatalities and identify opportunities for prevention to promote recovery and to collaborate to leverage existing resources to prevent substance misuse. (Clark County, 2024)

At the conclusion of the one-year term, the Opioid Task Force will provide a report summarizing their work and provide relevant legislative recommendations.

To access information, agendas, and minutes of the Opioid Task Force, visit: https://bit.ly/4aSEkgx.

Southern Nevada Opioid Advisory Council

The Southern Nevada Opioid Advisory Council (SNOAC) is a community working group championed by SNHD and PACT Coalition. The SNOAC is dedicated to addressing the substance use crisis in Southern Nevada through a systemic, evidence-based approaches. The mission involves unique community collaborations and a commitment to health equity, data evaluation, and accountability. SNOAC operates under a four-pillar vision encompassing prevention, rescue, treatment, and recovery, all rooted in guiding principles. All initiatives aim to create supportive environments and develop sustainable solutions for substance misuse and overdose prevention in the region. (Southern Nevada Health District, n.d.)

For more information, visit SNOAC: https://www.snoac.org/.

[This page left blank intentionally.]

Identified Gaps in Addressing the Opioid Epidemic in Clark County

Across this report, looking at the findings from primary and secondary data collection, the team has identified the following gaps, listed below in no certain order.

Accessibility and Capacity of Treatment Facilities:

- Current Situation: Existing facilities range from inpatient mental health hospitals to various rehabilitation centers offering detox, inpatient, and outpatient services
- Gap: Many facilities are at capacity and unable to meet the high demand, particularly impacting uninsured individuals and residents in underserved areas.
- Recommendation: Establishing a new treatment center would expand access to opioid addiction services, addressing current capacity limitations.

Substance Use Treatment Services:

- Current Situation: A variety of opioid treatment programs exist, but they are not sufficient to meet the growing needs or population of Clark County.
- Gap: Insufficient substance use treatment services across the county.
- Recommendation: Enhanced treatment options are essential to align with funding priorities and address service gaps, ensuring comprehensive care for all residents.

Long-Term Recovery Supports and Aftercare Services:

- Current Situation: Existing treatment services often lack comprehensive long-term support for people within the community (i.e., a recovery-oriented system of care).
- Gap: There is a critical need for more long-term recovery and aftercare services such as recovery housing, sober living homes, ongoing counseling, and employment training.
- Recommendation: These services are vital for maintaining sobriety and preventing recurrence of use, thus improving health and wellness, reducing long-term healthcare costs, and improving public safety.

Youth Prevention Education:

- Current Situation: Current efforts include some prevention programs, but there are not sufficient resources to for universal reach or comprehensive for all populations at risk.
- Gap: Need to expand age-appropriate prevention programming across various settings, including afterschool programs and for justice-involved youth.

- Recommendation: Prevention education helps reduce the initiation into opioid use, thereby addressing upstream factors that contribute to early age of first use.

Syndemic Integration for Infectious Diseases:

- Current Situation: Some strategies exist to address infectious diseases among PWUD, but funding is limited or siloed in expanding whole-person care.
- Gap: Insufficient resources to address the "shared network" of PWUD at risk for infectious diseases (i.e., a "syndemic")
- Recommendation: A person-centered approach is needed to reduce substance use-related harm and prevent disease transmission among underserved communities.

Stigma Reduction:

- Current Situation: Stigma among the public and healthcare providers remains a significant barrier to care for SUD. SNHD offers harm reduction training, but resources are limited.
- Gap: Need for targeted media campaigns and stigma reduction training for professionals and community members.
- Recommendation: Reducing stigma is crucial to improve access to care and support for individuals with substance use disorders. Educating stakeholders about harm reduction science is essential to shift public perception and improve policymaking.

Overdose Prevention Strategies:

- Current Situation: Efforts include naloxone distribution and overdose education.
- Gap: Need for expanded strategies to achieve naloxone saturation and accessibility to harm reduction supports.
- Recommendation: Expanded naloxone distribution and prevention sites can significantly reduce overdose fatalities.

Low-Barrier and Affordable Housing:

- Current Situation: The housing market is challenging, further burdening those with opioid use disorder or those in recovery. There is some recognition of the need for recovery housing, but efforts are limited.
- Gap: Critical need for low-barrier and affordable housing for individuals with substance use disorders, especially as part of a comprehensive public health approach.

- Recommendation: Stable housing is a fundamental need that supports recovery and reduces vulnerability to recurrence of use. Addressing housing instability directly correlates with reducing overdose risks and promoting well-being.

Peer Recovery Support and Workforce Development:

- Current Situation: Peer support programs exist but are not sufficiently scaled due to lack of resources.
- Gap: Need to expand workforce development and support for individuals with lived experience.
- Recommendation: Expanding peer support programs enhances the effectiveness of recovery efforts and builds a resilient support network.

Contingency Management Programs:

- Current Situation: Few programs address polysubstance use with evidence-based interventions. No in-person Contingency Management services are available in Clark County.
- Gap: Need for resources to establish in-person Contingency Management programs.
- Recommendation: Contingency Management programs are effective in promoting abstinence and addressing co-occurring substance use disorders.

Linkage to Care:

- Current Situation: SNHD and partners provide linkage to care services in multiple settings, but resources are limited to achieve sufficient reach.
- Gap: Opportunities to increase outreach and support for people who use drugs, particularly in overdose hotspots.
- Recommendation: Effective linkage to care improves recovery outcomes and reduces overdose incidents.

Specialized Programs for Parents in the Child Welfare System:

- Current Situation: There is a recognized need but limited funding for these types of support.
- Gap: More resources are needed to create specialized programs for parents with children in the child welfare system.

- Recommendation: Tailored support services for parents can improve family stability and outcomes for children.

Urban and Rural Disparities:

- Current Situation: Efforts to address overdose prevention and opioids are primarily concentrated in urban areas of the county, like Las Vegas.
- Gap: Lack of targeted collaboration and support for rural areas in Clark County.
- Recommendation: Ensuring equitable access to services across urban and rural areas is essential for comprehensive public health coverage.

Data System for Universal Care Plan:

- Current Situation: There is no integrated data system in place across the health care and public health systems.
- Gap: Need for a data system that produces a universal care plan integrated across electronic health records and interfaces with the health department.
- Recommendation: An integrated data system enhances care coordination and ensures consistent support across various health services.

By addressing these identified gaps, Clark County can enhance its response to the opioid epidemic, improve access to comprehensive care, and support sustainable recovery efforts.

[This page left blank intentionally.]

Funding and Recommended Implementation Plan

The County Commission has the ultimate funding approval authority. S.B. 390 of the 2021 Legislative Session dictates funds must be utilized to abate opioid use and misuse within the Clark County jurisdiction. Any organization seeking to use county allocated opioid settlement dollars will need to present to the County Commission their project along with a detailed budget and intended outcomes that align with the priorities set forth by S.B. 390 and this Assessment.

Grants awarded through the State of Nevada for the purpose of opioid abatement will align with the following plan and must be approved through the County Commission for any funds being used by a county entity.

The following outlines the eligible uses of grant money by a state, local, or tribal government entity may allocate money pursuant to S.B. 390, paragraph (b) of subsection 1 to:

(a) Projects and programs to:
   1) Expand access to evidence-based prevention of substance use disorders, early interventions 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) Reduce the incidence and severity of neonatal abstinence syndrome;
   3) Prevent incidents of adverse childhood experiences and increase early intervention for children who have undergone adverse childhood experiences and families of such children;
   4) Reduce the harm caused by substance use;
   5) Prevent and treat infectious diseases in persons with substance use disorders;
   6) Provide services for children and other persons in a behavioral health crisis and the families of such persons;
   7) Provide housing for persons who have or are in recovery from substance use disorders;

(b) Campaigns to educate and increase awareness of the public concerning use and substance use disorders;

(c) 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;

(d) Evaluation of existing programs relating to substance use and substance use disorders;

(e) Development of the workforce of providers of services relating to substance use and substance use disorders;

(f) The collection and analysis of data relating to substance use and substance use disorders; and

(g) Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling.

Clark County Funding Priority

Clark County Center for Substance Recovery

Currently, across Clark County, there are opioid treatment programs that offer a range of services, including detoxification, MAT, and counseling. These facilities range in scope from inpatient mental health hospitals with the ability to treat acuate intoxication to various rehabilitation centers which do a combination of detox, inpatient, and outpatient services.

Despite the availability of treatment facilities, there are significant gaps in accessibility for many residents, particularly those without insurance or those living in underserved areas. The capacity of existing facilities often cannot meet the high demand for services. Additionally, there is a need for more integrated care systems that not only focus on treating addiction, but also address the underlying social and mental health issues associated with substance use disorders. This can include housing, employment support, and mental health services. Finally, there is a lack of long-term recovery and aftercare services, which are vital for maintain sobriety and preventing relapse. Services such as sober living homes, ongoing counseling, and employment training are needed to support individuals in their recovery journey.

With the establishment of the Clark County Center for Substance Recovery, the issues presented could be combatted in order to continue to address the opioid epidemic in Clark County. The following is a summary of the goals and objectives of the Clark County Center for Substance Recovery:

Enhanced Access to Specialized Care

Increase Treatment Capacity: A new treatment center would expand the availability of opioid addiction services, including detoxification, MAT, and counseling. Moreover, the treatment center will be a valuable resource for adolescents and juveniles in the community. This is crucial in a metropolitan area where current facilities may be at capacity and unable to meet the growing demand.

Specialized Programs: With the establishment of the new center, there is an opportunity to offer specialized programs tailored to diverse populations, such as people with co-occurring mental health disorders, adolescents, and juveniles.

Reduction in Overdose Deaths

Immediate Intervention: Increased access to treatment could lead directly to a reduction in overdose deaths. Treatment centers provide necessary interventions like Naloxone distribution and emergency care that can save lives in acute situations.

Long-term Health Improvements: Ongoing treatment and support services help individuals achieve and maintain sobriety, significantly reducing the risk of fatal and non-fatal overdoses.

Economic Benefits

Reduce Health Care Costs: Effective treatment could lead to a reduction in the need for emergency medical services and hospitalizations related to overdoses. It could lead to a decrease in overall health care costs.

Social and Community Impact

Improved Public Safety: Treatment centers could help reduce drug-related crime and improve public safety by addressing the root causes of addiction. This could lead to a more stable and safe community.

Community Engagement and Support: Establishing a new center could strengthen community ties and promote a supportive environment that is critical for recovery. This includes creating opportunities for community-based recovery programs and partnerships with local businesses and educational institutions.

Education and Prevention

Awareness and Stigma Reduction: A treatment center also serves as a hub for education and awareness campaigns that could help reduce the stigma associated with addiction. By promoting understanding and support, the center could encourage more individuals to seek help early.

Preventive Education: The center could provide preventive education to at-risk populations, including youth and young adults, which is essential for reducing the initiation into opioid use.

Research and Development

Innovations in Treatment: A new center could also be a site for research and development of new treatment methods and interventions. Collaboration with academic institutions and participation in clinical trials could lead to innovations that improve treatment outcomes not only locally, but on a broader scale.

Broaden Support Networks

Integration of Services: By integrating various services, such as mental health care, social services, and legal aid, into the treatment process, a new center could provide a holistic approach to recovery, which is more effective in the long-term.

Therefore, the establishment of a new opioid treatment center in the Greater Las Vegas Area could bring multifaceted benefits, addressing both immediate and long-term needs of individuals struggling with opioid addiction. This initiative could not only enhance the health and safety of the community, but it could also contribute positively to its economic and social fabric. The new center is not just a response to a crisis – it is an investment in the future health and well-being of Clark County.

A full overview of the proposed Clark County Center for Substance Recovery is available in Appendix 4.

Recommended Strategies: Southern Nevada Health District

Overview

The Southern Nevad Health District is not a named entity in the One Nevada Agreement, however, is required per NRS 433.744 to complete a needs assessment and plan to be eligible to apply for such funds. As such, SNHD utilized the community-based coalition SNOAC's four (4) pillars to best contextualize current SNHD and partners efforts to address opioid use and overdose prevention, and a plan to mitigate these efforts, should funding become available. Included below are areas of current funding, and those sources, to maximize expenditures across contributions. The four (4) pillars (described below) are rooted in guiding principles health equity, community, data, evaluation, social determinants of health (SDoH), and accountability, which mirror the guidance set forth in the NRS for these efforts. More details on the pillars and community programs can be found at: https://www.snoac.org/.

Prevention

Definition: Projects oriented towards prevention aim to apply interventions in our community that reduce risk factors and increase protective factors surrounding substance use and prevention.

Current and future efforts

- SNOAC: Build and strengthen coalitions that support the full spectrum of opioid strategies to address care for Clark County. This includes serving as a collaborative platform for diverse stakeholders, including public health agencies, community organizations, healthcare providers, public safety, and individuals with lived experience, to work together to reduce overdose and opioid-related harm. *Current funding: ODTA:LOCAL.*

- Youth Prevention Education: The above assessment findings identified a need to expand age-appropriate prevention programming, from preschool to high school, across various settings such as afterschool programs, faith-based organizations, summer camps, and other community-based environments. Additionally, specialty indicated evidence-based prevention programs should be implemented for justice-involved youth in collaboration with probation officers and other professionals. These programs should be measured using evidence-based tools provided through the curriculum and a continuous quality improvement evaluation framework. This framework will incorporate feedback from students, families, and educators to participate in the strategy and implementation of the curricula. *Not currently funded via SNHD.*

- Syndemic integration for infectious disease: SNHD employs strategies to address the "shared network" of individuals who use substances and those at elevated risk for infectious diseases. This project would adopt a person-centered approach to reduce substance use-related harm, prevent overdose fatalities, and decrease transmission rates of HIV and HCV among underserved

communities in Clark County, including youth, rural areas, BIPOC communities, and MSM/LGBTQ+ populations. *No current on-going funding identified.*

- Targeted media campaign to reduce stigma: A targeted media campaign to address stigma among the public and healthcare providers, which are significant barriers to care for people with substance use disorders or those who use drugs seeking services. This campaign should include public awareness initiatives about substance use and overdose, and a focus on stigma reduction training for healthcare and law enforcement professionals. By increasing awareness and reducing stigma, the campaign aims to improve access to care and support for affected individuals. *Partial funding: ODTA:LOCAL; No current on-going funding identified.*

Rescue

Definition: Interventions and approaches that are implemented after substance misuse has already developed and are aimed at preventing overdose and improving quality of life and health while using substances.

Current and future efforts

- Overdose education and naloxone distribution: As mentioned above, SNHD is working toward naloxone saturation in Clark County. To reach saturation, additional funding is needed to meet naloxone saturation targets. Additionally, expanded strategies to reduce fatal overdose include first responder naloxone leave-behind efforts, increased targeted community distribution, emergency department distribution, and expanding novel, on-demand naloxone access strategies. Expanded efforts should also consider opportunities to make naloxone accessible 24 hours a day to those who need it; reflected in the findings from the SNHD assessment and time of day fatality data presented above. *Current funding FR-CARA, State Opioid Response, COSSUP.*

- Test strip distribution: Community members and stakeholder partners participate in overdose prevention by accessing on-demand, online training and becoming distribution partners for test strips (currently fentanyl test strips and xylazine test strips). Expanding access to test strips through mail distribution is a key strategy in addressing this need. *Current funding ODTA:LOCAL.*

- Southern Nevada Post Overdose Response Team (SPORT): SNHD is currently collaborating with first responder agencies to expand SPORT across Clark County. The primary goal of this program are to prevent fatal overdoses, connect survivors with harm reduction resources, provide evidence-based treatment for substance use disorders, and offer recovery support. Additionally, this program aims to engage individuals at high risk for overdose who are not currently receiving services or practicing overdose prevention measures by meeting them where they are at and connecting to care mirroring efforts to use low threshold risk reduction engagement from the HIV counseling field. *Current funding BJA COSSUP.*

- Linkage to Care through navigators: SNHD currently provides linkage to care across various populations and settings, including SNHD's own Linkage to Action team (community and public safety), Trac-B Exchange (community), rural drug courts (public safety), hospital emergency rooms (healthcare), The LGBTQ+ Center's LinkUp Team (community), and Roseman's EMPOWERED program for pregnant people (community). There are additional opportunities to increase the community outreach team to support people who use drugs, linking them to care and continuing engagement in recovery, continuing to utilize navigators and prioritize those navigators with lived experience. This includes increased access to outreach resources such as wound care kits, hygiene kits, and educational materials, particularly targeting Clark County overdose "hot spots." *Partial funding: ODTA:LOCAL; No current on-going funding identified for expansion.*

- Education on harm reduction and drug-related stigma: As current data assessment demonstrated, there is an on-going need to provide education to community members on harm reduction and drug-related stigma. Presently, SNHD offers these training courses quarterly at no cost; information is presented primarily online and tailored to audiences upon request. Additionally, on-going efforts strive to inform and educate stakeholders about the science of harm reduction by providing scientific evidence to policy makers and key communities impacted by overdose. *Current funding: ODTA:LOCAL.*

- Understand need and readiness for Overdose Prevention Sites (OPS) in Clark County: While there has been much national interest in OPS, little is known locally about community readiness for or capacity to implement such a novel, polarizing program. Efforts to better understand the implementation potential are needed, such as assessing community readiness, conducting a feasibility study, and forming a community coalition/working group are essential steps toward consideration of an implementation plan. *No current funding are identified.*

Treatment

Definition: Interventions and approaches that are aimed at helping individuals to end their chaotic relationship with substance use and reduce drug seeking behaviors.

Current and future efforts

- Clinician and Health System Education on Best Practices: To ensure access to the best possible care, it is essential to educate Clark County providers to build comfort and confidence among clinicians to support the provision of pain care as well as medications for opioid use disorder (MOUD), inclusive of training efforts aimed at advancing clinician best practices for acute, subacute, and chronic pain treatment, including opioid prescribing, as described in the CDC

Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022.[9] *Current funding ODTA:LOCAL.*

- Continency Management Program: To address polysubstance use as an overdose risk, specifically the co-use of stimulants and opioids, and increase access to evidence-based treatment, additional resources are needed community-wide. Contingency Management is an evidence-based intervention that utilizes positive reinforcement to promote behavior change and promote abstinence through a structured rewards system. This project's proposed project aims are to evaluate the landscape of capacity to contract with an existing State Substance Abuse Prevention & Treatment Agency (SAPTA) certified substance use disorder (SUD) treatment team to establish an in-person Contingency Management (CM) program to address stimulant use disorder (StUD) or co-occurring StUD and opioid use disorder. *No current on-going funding identified.*

- Low barrier treatment access: Assessment findings underscore the critical need for low-barrier SUD treatment services, particularly emphasizing low barrier access to medications for opioid use disorders. This approach is vital for mitigating overdose risks and addressing the complex needs and underlying trauma of people who use drugs. To effectively implement such services, a comprehensive systems-level plan akin to the successes found with rapid stART for HIV treatment is imperative for ensuring swift and equitable access to treatment and support. *No current funding identified.*

Recovery

Definition: Interventions and approaches that support a person-centered model building on the strengths and resilience of individuals, families, and communities to achieve and maintain self-defined recovery through improved health, wellness, and quality of life.

Current and future efforts

- Peer Recovery Support & Workforce Development: Supporting individuals with lived experience is paramount in the SUD workforce. Presently, SNHD's partners offer peer support within SNHD's L2A program to assist individuals in finding support and engagement before release from incarceration. This program uniquely trains peers through their Forensic Peer Recovery Support Specialist Internship, bolstering the capacity and effectiveness of the peer workforce in Clark County. Additional opportunities to pair people seeking recovery with certified peers and efforts to scale up workforce development should be prioritized. *Current funding ODTA:LOCAL.*

- Recovery housing: Multiple assessments above consistently highlighted the urgent need for stable and affordable housing as a crucial component of any identified overdose prevention strategy. While slightly outside the current scope of the public health department and recognizing the direct

[9] More details on these guidelines can be found at: https://www.cdc.gov/overdose-prevention/hcp/toolkits/2022-clinical-practice-guideline-partner-toolkit.html.

correlation between housing instability and increased vulnerability to overdose risks, our approach will focus on identifying partners and coalition groups currently working to identify supportive recovery housing to gain a better understand how public health can help reduce barriers to housing access. By addressing this fundamental need, we aim to create a supportive environment that fosters stability and resilience, thereby mitigating the risk of overdose and promoting holistic well-being within our community. *No current funding identified.*

[This page left blank intentionally.]

Financial Policies and Procedures

Pursuant to Section 9.9 (1) (b) of S.B. 390, Clark County and SNHD agree to establish policies and procedures for the administration and distribution of the grant money for which each governmental entity is applying. Moreover, both entities will establish requirements governing the use of the grant money pursuant to Section 9.9 (1) (c) of S.B. 390.

[This page left blank intentionally.]

Conclusion

As presented, this Assessment has provided a solid foundational overview of the trends and needs pertaining to opioid use in Clark County. Using community engagement methods, qualitative results supplemented available quantitative data. Thus, risk factors that contribute to opioid use, the use of substances, and the rates of opioid use disorders, other substance use disorders, and co-occurring disorders in Clark County were presented. Moreover, this Assessment provided recommendations and proposed action plans by Clark County and the Southern Nevada Health District. The information presented will contribute to the ongoing discussions in the community to solve the opioid epidemic.

[This page left blank intentionally.]

References

Census Reporter. (2022). *Clark County, NV*. Retrieved April 30, 2024, from Census Reporter Profile Page: https://censusreporter.org/profiles/05000US32003-clark-county-nv/

Centers for Disease Control and Prevention. (2023, April 17). *YRBSS Overview*. Retrieved from Adolescent and School Health: https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm

Centers for Disease Control and Prevention. (2024, May 17). *CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI): Overview*. Retrieved from Agency for Toxic Substances and Disease Registry: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html

Clark County. (2024). *Clark County Regional Opioid Task Force*. Retrieved from Clark County: https://www.clarkcountynv.gov/government/departments/opioid_task_force/index.php

Clark County Department of Family Services. (2024, April). Opioid-Related Referrals. Las Vegas, Nevada, USA.

Clark County Department of Finance. (n.d.).

Clark County Detention Center. (2024, June). Inmate Population Opioid Use Disorders Study: Report on Findings. Las Vegas, Nevada, USA.

Eighth Judicial District Court. (2019-2023). Drug of Choice Statistics for Juvenile Drug Court Participants. Las Vegas, Nevada.

Eighth Judicial District. (n.d.). *Juvenile Drug Treatment Court*. Retrieved May 2024, from Eighth Judicial District: http://www.clarkcountycourts.us/res/specialty-courts/JDC_Flyer.pdf

Gerrity, D., Crank, K., Oh, E. C., Quinones, O., Trenholm, R. A., & Vanderford, B. J. (2024, January 15). Wastewater surveillance of high risk substances in Southern Nevada: Sucralose normalization to translate data for potential public health action. *Science of The Total Environment, 908*. Retrieved from https://doi.org/10.1016/j.scitotenv.2023.168369

Ghertner, R., & Groves, Ph.D., L. (2018, September 11). The Opioid Crisis and Economic Opportunity: Geographic and Economic Trends. *ASPE Research Brief*, p. 22. Retrieved April 30, 2024, from https://aspe.hhs.gov/sites/default/files/private/pdf/259261/ASPEEconomicOpportunityOpioidCrisis.pdf

Irvine, M. e. (2022). Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: A modelling study. *The Lancet Public Health, 7*(3). doi:10.1016/s2468-2667(21)00304-2

Jarosz, B. (n.d.). *How Did State Populations Change 2010-2020?* Retrieved from Population Reference Bureau: https://www.prb.org/resources/how-did-state-populations-change-2010-2020/#:~:text=Highlights%3A,and%20Wyoming%20remains%20the%20smallest

Jones, C. (2017). The paradox of decreasing nonmedical opioid analgesic use and increasing abuse or dependence- An assessment of demographic and substance use trends. *Addictive behavors, 65*, 229-235. Retrieved April 30, 2024, from https://doi.org/10.1016/j.addbeh.2016.08.027

Larson Institute: School of Public Health, University of Nevada, Reno. (2022). *Nevada State Health Assessment*. Retrieved from Nevada Division of Public and Behavioral Health: https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/About/AdminSvcs/DPBH-SHA-2022.pdf

Nevada Legislature. (2019, June). *Assembly Bill 236*. Retrieved from Nevada Legislature: https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6419/Text

Nevada Legislature. (2021, April 8). *Minutes of the Senate Committee on Health and Human Services- Eighty-first Session- April 8, 2021.* Retrieved April 30, 2024, from Nevada Legislature: https://www.leg.state.nv.us/Session/81st2021/Minutes/Senate/HHS/Final/787.pdf

Nevada Legislature. (2021, June). Senate Bill 390. *Nevada Legislature.* Retrieved from https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8095/Overview

Office of Informatics and Epidemiology, Southern Nevada Health District. (2024). Naloxone program data.

Office of National Drug Control Policy, Executive Office of the President, The White House. (2024). *High Intensity Drug Trafficking Areas Program: 2024 Report to Congress.* Washington, D.C. . Retrieved from https://www.whitehouse.gov/wp-content/uploads/2024/02/2024-HIDTA-Annual-Report-to-Congress.pdf

Pickett, S., Powell, K., Lang , D., & Carpenter, J. (n.d.). *Illinois Opioid Crisis Community Survey Results.* Retrieved from Advocates for Human Potential, Inc.: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/Illinois_Opioid_Crisis_Community_Survey_Results.pdf

Southern Nevada Health District. (2023). Drug overdose data prepared b Office of Informatics and Epidemiology using NV-EDRS.

Southern Nevada Health District. (2024). Drug overdose data prepared by Office of Epidemiology using CHIA.

Southern Nevada Health District. (2024). Drug overdose data prepared by Office of Epidemiology using ESO.

Southern Nevada Health District. (2024). Rapid Drug Analysis and Research National Institute for Standards and Technology. Retrieved 2024

Southern Nevada Health District. (n.d.). *Southern Nevada Opioid Advisory Council.* Retrieved from Southern Nevada Health District: https://www.southernnevadahealthdistrict.org/programs/substance-use-and-overdose-prevention/snoac/

Title 40: Chapter 439: Administration of Public Health. (n.d.). Retrieved from Nevada Revised Statutes: https://www.leg.state.nv.us/nrs/nrs-439.html

U.S. Census Bureau. (2020). *Decennial Census, DEC Redistricting Data (PL 94-171), Table P1.* Retrieved April 24, 2024, from RACE: https://data.census.gov/table/DECENNIALPL2020.P1?g=050XX00US32003.

U.S. Census Bureau. (2022). *American Community Survey, ACS 1-Year Estimates Subject Tables, Table S0101.* Retrieved April 30, 2024, from Age and Sex: https://data.census.gov/table/ACSST1Y2022.S0101?g=050XX00US32003

U.S. Census Bureau. (2023). *Quick Facts: Clark County, Nevada.* Retrieved April 24, 2024, from https://www.census.gov/quickfacts/clarkcountynevada

U.S. Census Bureau. (Updated annually). *American Community Survey (ACS).* Retrieved April 24, 2024, from https://www.census.gov/programs-surveys/acs/

U.S. Census Bureau. (Updated annually). *Population Estimates Program (PEP).* Retrieved April 24, 2024, from https://www.census.gov/programs-surveys/popest.html

U.S. Centers for Disease Control and Prevention. (2024, May 7). *Opioid Dispensing Rate Maps.* Retrieved from Overdose Prevention: https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/rxrate-maps/opioid.html

Appendix 1: Clark County Community Stakeholder Survey Instrument

(Starts on the next page)

Community Survey on Opioid Use in Clark County

Clark County is seeking to gather information and insight from community stakeholders to make recommendations for our community's opioid needs assessment. This survey will be asking you questions about opioid use in Clark County to better identify community strengths, gaps, barriers, and needs. Your input is valuable and will help to inform our community's action plan and prioritize spending of the opioid litigation funding.

This survey is open from April 22, 2024 until May 13, 2024.

Survey Information

Your participation in this survey is completely voluntary, and you can close the survey at any time.

To take this survey, we ask that you be at least 18 years old.

This survey is anonymous, and it should take less than 10 minutes to complete.

This survey is open from April 22, 2024 until May 13, 2024.

For any questions related to this survey, please email Katie Walpole at Kathleen.Walpole@ClarkCountyNV.gov.

Clark County Resident

This survey is only open to Clark County residents. This includes those that live in an incorporated city (e.g., Las Vegas) in Clark County.

1. Are you a Clark County resident?

   Mark only one oval.

   - ◯ Yes *Skip to question 2*
   - ◯ No *Skip to section 4 (End of the Survey)*

Skip to question 2

End of the Survey

As you have selected that you are not a Clark County resident, you cannot complete this survey.

Please email Kathleen.Walpole@ClarkCountyNV.gov for any questions.

Demographics

The following questions are optional.

2. What zip code do you reside in?

_____

3. What is your age?

Mark only one oval.

- ◯ 18-24 years old
- ◯ 25-34 years old
- ◯ 35-44 years old
- ◯ 45-54 years old
- ◯ 55-64 years old
- ◯ 65+ years old

4. Do you consider yourself Hispanic/Latinx?

Mark only one oval.

- ◯ No, not of Hispanic, Latino/a, or Spanish origin
- ◯ Yes, Mexican, Mexican American, Chicano
- ◯ Yes, Puerto Rican
- ◯ Yes, Cuban
- ◯ Yes, another Hispanic, Latino/a, or Spanish origin

5. What is your race? Select all that apply.

Check all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian or Asian American
- ☐ Black or African American
- ☐ Middle Eastern or Northern African
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other: _____

6. Please select the groups that best describe you. Select all that apply.

Check all that apply.

- [ ] Person who uses opioids
- [ ] Person in recovery from opioid use disorder
- [ ] Family member of a person with an opioid use disorder
- [ ] Health care provider
- [ ] Behavioral health care provider
- [ ] Substance use treatment provider
- [ ] Public health professional
- [ ] Education professional
- [ ] Local government professional
- [ ] State government professional
- [ ] Faith-based/religious organization
- [ ] Child welfare agency
- [ ] Law enforcement
- [ ] Justice system professional
- [ ] First responder
- [ ] Mutual aid organization
- [ ] Non-profit organization professional
- [ ] Research professional
- [ ] Managed care organization
- [ ] Prevention profesisonal
- [ ] Harm reduction professional
- [ ] Homeless services professional
- [ ] None of these

Opioid Use in Clark County

7. How big of an issue is opioid use in Clark County?

Mark only one oval.

- ◯ It is a huge issue
- ◯ It is a medium issue
- ◯ It is a small issue
- ◯ There is no problem
- ◯ Other drugs are more of an issue
- ◯ I don't know
- ◯ Other: _____

8. Have you been personally impacted by opioid use? Select all that apply.

Check all that apply.

- ☐ Yes, I use/have used opioids
- ☐ Yes, a family member(s) has/had issues with opioids
- ☐ Yes, a friend(s) have/had issues with opioids
- ☐ No, I have not been personally impacted by opioid use
- ☐ I don't know

9. Have you heard about any of the following opioid-related issues in your community in the past 12 months? Select all that apply.

Check all that apply.

- ☐ Fatal and non-fatal overdoses
- ☐ Opioid/heroin/fentanyl related crimes
- ☐ Misuse of prescription opioids
- ☐ Problems accessing opioid treatment
- ☐ Concerns about fentanyl in the community
- ☐ I have not heard about any opioid-related issues in the community

Opioid Use in Clark County

10. Where did you hear about these opioid-related issues in the community? Select all that apply.

Check all that apply.

- [ ] Local TV
- [ ] Radio
- [ ] Social media
- [ ] Local printed news media
- [ ] Local online news media
- [ ] Colleagues
- [ ] Friends
- [ ] Family members
- [ ] Work meetings/reports
- [ ] Other: _____

11. Have you heard about these opioid-related initiatives in the community? Select all that apply.

Check all that apply.

- [ ] Drug take back/disposal
- [ ] Naloxone/Narcan training
- [ ] Medication-assisted treatment
- [ ] Syringe services programs (e.g., needle exchange programs)
- [ ] Diversion programs
- [ ] School-based prevention education
- [ ] Community education events
- [ ] Specialty courts
- [ ] Medication-assisted treatment in the Clark County Detention Center
- [ ] Peer support in the emergency room
- [ ] None of these

12. What do you think are the biggest opioid-related needs in Clark County? Select all that apply.

Check all that apply.

- [ ] Healthcare provider training on opioid prescribing and how to get people off of opioids if they are dependent
- [ ] Public awareness
- [ ] Stigma awareness/education
- [ ] School-based prevention education
- [ ] Alternatives to incarcertation
- [ ] Access to drug checking for people who use drugs
- [ ] Increase access to Naloxone/Narcan
- [ ] Increase low-barrier access to treatment
- [ ] Recovery support services
- [ ] Access to local opioid data
- [ ] Awareness of opioid related initiatives

13. What are Clark County's strengths that help address the opioid crisis? Select all that apply.

Check all that apply.

- [ ] Community partnerships
- [ ] Community cohesion and involvement
- [ ] Strong community leadership
- [ ] Public awareness
- [ ] Educational programs
- [ ] Resources (e.g., staff, funding, and programs)
- [ ] Substance use treatment providers
- [ ] Prevention education
- [ ] Harm reduction services (e.g., outreach, syringe services, Naloxone/Narcan, drug checking, HIV testing, Hepatitis C testing, etc.)
- [ ] Sober recreational activities
- [ ] None
- [ ] I don't know
- [ ] Other: _____

14. What are some of the gaps, barriers, and challenges related to addressing opioid use in Clark County? Select all that apply.

Check all that apply.

- [ ] Lack of resources (e.g., staff, funding, and programs)
- [ ] Limited knowledge of available resources
- [ ] Lack of substance use treatment services
- [ ] Lack of public awareness
- [ ] Lack of educational programs
- [ ] Poor leadership
- [ ] Limited collaboration or partnerships
- [ ] Insurance
- [ ] Lack of access to treatment
- [ ] Transportation
- [ ] Stigma or judgmental providers
- [ ] Lack of recovery support services
- [ ] Low-barrier and/or affordable housing
- [ ] There are no challenges
- [ ] I don't know
- [ ] Other: _____

Opioid Use in Clark County

15. Do you think the opioid crisis has impacted some groups of people worse than others in Clark County?

Mark only one oval.

- ◯ Yes *Skip to question 16*
- ◯ No *Skip to question 17*

Skip to question 17

Opioid Use in Clark County

16. If yes, which groups?

Opioid Use in Clark County

17. If you could prioritize funding, which services would you prioritize? Select at least three (3) choices.

Check all that apply.

- [ ] Increase access to low-barrier substance use treatment services
- [ ] Increase access to low-barrier, walk-in availability (on-demand) of medication-assisted treatment
- [ ] Expand harm reduction services such as syringe services programs, outreach, drug checking (including fentanyl test strips, HIV/Hepatitis C testing, wound care, and Naloxone/Narcan)
- [ ] Increase prevention programming in schools
- [ ] Increase services that address underlying trauma
- [ ] Increase diversion and specialty court programs for justice-involved individuals
- [ ] Create specialized programs for parents with opioid use disorder who have child welfare involvement
- [ ] Increase access to low-barrier and/or affordable housing
- [ ] Increase recovery housing options
- [ ] Explore overdose prevention centers
- [ ] Increase Naloxone/Narcan distribution and the number of community members trained in reversing overdoses
- [ ] Stigma reduction awareness campaign/education
- [ ] Expand recovery support services such as peer recovery support services
- [ ] Strengthen data collection, sharing, and analysis to identify opportunities for intervention

18. Is there a strategy not listed that you would like to add? If so, what is it?

19. If you had the resources and time to create a program to address opioid use in Clark County, what services would it offer? Where would it be located?

Appendix 2: Open-Ended Responses to the Clark County Community Stakeholder Survey

I would like to see Narcan more accessible as well as making fentanyl less accessible in the hospitals.
I'd create a plan like drunk driving awareness was created. It would be available in all schools to include college. Community partners would provide prevention/resource classes to the community, and anyone charged with an opioid charge. Hospitals/medical centers would have on-going medical training to look for signs and how to address someone in crisis. To spread the awareness of how impactful this crisis is, it would be foolish to think there could be just one resource center/in one location. It would have to be multiple options and opportunities for education and prevention.
in high risk zip codes, vending machines for test strips, increased awareness campaigns
I'd expand treatment options in the central corridor, and I'd increase training/awareness for families.
Built into communities where people congregate
It would be a peer-run housing first/respite program with access to harm reduction services and linkages to treatment and permanent supportive housing. I.e. providing non-carceral housing to individuals on in-patient and detox waitlists, those without insurance or documentation, run by peers and residents.
Drug testing, housing, therapy; located in Clark county and Pahrump
I would create a program that had sober living but also job skills, help with mental health, and other resources for youth in the community. We are heavily lacking when it comes to resources for youth who have been affected by addiction.
Centrally located, then satellite sites around the valley still in reach of main bus routes. It would offer, SUD/ mental health treatment, MAT, psych, medication management, social services, job development, and housing all in one location.
Shine A Light downtown
CCSD- train teachers and staff to deal with overdose, be productive in removing drugs from school campuses, educate students on effects yearly
Education/awareness/information programming and commercials about the types and dangers of opioids.
I would create a centrally located holistic healthcare facility that addresses treatment, recovery, prevention, mental health, financial counseling, access to alternative pain treatments, and connected to a safe shelter.
yes I would place treatment supports at shelters and have scheduled time at homeless encampments
A place where addicts can explore different hobbies and learn life skills to get them back on their feet.
education, mentoring, sports/activities for youth. Youth that start portraying negative behaviors is mostly due to their environment and the individuals they are surrounded by. Increase prosocial behaviors and activities will help them choose better decisions.
Treatment Services for young adults with wrap around services to help them stay clean and become productive assets to the community

Have someone with more authority than a doctor check if medication prescriptions are necessary.
I would create an evidence-based practice that focuses on the trauma and other underlying causes of opioid addiction that provides clients pathways to recovery promoting economic stability, long-term mental health improvements, and community engagement. It would be located in a central area (within 5 miles of Clark County Government Center) and offer express shuttle services to areas of high demand or rideshare services to individuals in areas with lower demand.
i would create a low income/ no income affordable housing for homeless people and youth where they would have access to drug rehab, testing and meals to help them get clean and back as functioning members of society. i would locate it on the east side of Las Vegas near Charleston and eastern area. this is where i notice the most homeless and drug use.
I want to start with our schools. Incorporate drug education into CCSD starting in the Kindergarten. The conversation must carry through to high school. Our efforts should be focused on educating our kids, so they never use drugs, as opposed to focusing only on those who are using. The opioid settlement fund should be used to get resources to both groups.
Informal counseling at a safe house located near the schools.
Local hospitals.
There would have to be locations in all parts of the city for success! There can be a main, and this main location would make sure that smaller branches are functioning up to code
Drs. shouldn't prescribe Opioids without education and follow up like Diabetes. You shouldn't be able to Dr or hospital shop to get drugs.
Services for pregnant women and near the medical providers.
It would be located at a treatment center and there should be a unit taught in State of Nevada Health Curriculum for 9th graders.
Various treatment locations throughout the valley, inpatient services increased individual treatment, other support options outside of AA
Programming in 89109
Close to hospitals, close to major bus stops, and near CCDFS campus
Treatment, peer support,90 day inpatient options, trauma focus
Childcare for women with children addressing an opioid or stimulant disorder
A center that provides information and access to services all in one location, e.g. substance abuse treatment, housing resources, mental health providers, and healthcare providers. It would be a one stop shop for all the needs, so individuals aren't having to meet with different agencies in different locations. They can attend multiple appointments to address all their needs in one location. This should be located centrally so that it is closer to the areas with lower income and transportation issues. If possible, have multiple locations. DJJS has a program called The Harbor that could be used to model this program with multiple locations throughout the valley.
Fentanyl Task Force located in Central Las Vegas
Educate the young regarding horrors of drug use and stop enabling the adults who continue to use.
Unknown (3)

Appendix 3: Final Report: Southern Nevada Health District Stakeholder & Community Engagement Surveys

(Starts on the next page)

SOUTHERN NEVADA HEALTH DISTRICT OVERDOSE DATA TO ACTION

Community Needs Assessment

Report prepared by Nevada Institute for Children's Research and Policy
University of Nevada, Las Vegas

Table of Contents

Southern Nevada Health District
Overdose Data to Action
Community Needs Assessment

Executive Summary

In April 2024, Nevada Institute for Children's Research and Policy (NICRP), in collaboration with the Southern Nevada Health District (SNHD), conducted a community needs assessment to better understand the barriers to overdose prevention in Clark County, Nevada, and to provide recommendations for addressing the contributors to overdose.

To facilitate the needs assessment, a project team was assembled to develop the goals and objectives of the community needs assessment, provide feedback on the tools to be used, and assist in interpretation of results. Based on the team's identified priorities, two instruments were developed: 1) a survey for people who use drugs to better understand barriers to overdose prevention and 2) a community partner interview to understand the barriers from the service perspective. Survey participants were recruited by the SNHD Linkage to Action (L2A) team and other direct service project partners. Interview participants were primarily SNHD community partners. Below are key findings from the Survey for People Who Use Drugs and the Community Partner Interview.

Key Findings from the Survey for People Who Use Drugs

<u>Harm reduction services</u>

- Less than half of respondents (43.2%) had not tried to access harm reduction services in the past.
- Among the harm reduction services of syringe exchange, test strips, Narcan/naloxone, and drug supply testing:
    - Narcan/naloxone was the service used most by respondents (50.3%), followed by syringe exchange (43.9%),
    - Test strips were heard of most (36.1%), and
    - Drug supply testing was the service respondents were most interested in learning more about (31.6%), followed by test strips (30.3%).
- The majority of participants agreed or strongly agreed that harm reduction services/supplies are important tools to decrease overdose (91.6%).

<u>Transportation</u>

- More than half (52.9%) of respondents disagreed or strongly disagreed that transportation was a barrier to accessing harm reduction services.
- Of those who indicated that transportation was a barrier, the majority (82.5%) indicated that they agreed or strongly agreed that they would be more likely to access harm reduction services if provided with bus passes.

Housing

- Housing and help finding resources for housing was cited as the most needed resource in the community.
- The largest percentage of respondents indicated that they spend their nights on the street (31.6%).
- More than half (56.8%) of respondents indicated that their current housing situation was unstable or very unstable.
- Almost two-thirds (65.8%) of respondents indicated that they were unsatisfied or very unsatisfied with their current housing situation.

Stigma

- Over half of respondents indicated that they have been treated differently or experienced stigma or discrimination as a result of their substance use (59.4%).
- Respondents were most likely to be treated differently or experience stigma or discrimination with police/law enforcement (24.6%) and in healthcare settings (19.6%).
- When asked what they needed to use more safely, most respondents reported needing a home or a safe environment.
- To access the things needed to use more safely, respondents indicated they need reliable transportation and more harm reduction or needle exchange sites.

Key Findings from the Community Partner Interview

- According to community partners, an unsafe drug supply (94.7%), lack of housing (89.5%), and stigma (89.5%) are the top three contributors to overdose in the community.
- Those working at self-supported grant-funded agencies indicated that it is difficult or very difficult to access funding to support the work they do in the community (86.7%).
- Community partners would like to see the following data collected or shared with them:
    - More disaggregated overdose data, including data for specific demographics and the locations of overdoses in the community,
    - Real-time data,
    - Information about what specific substances are being used and where in the community they are being used,
    - Specific locations where organizations are providing services in the community to avoid duplicative efforts, and
    - Data about harm reduction successes among organizations in the community.
- With regard to stigmatizing language:
    - Most reported they have sometimes or often heard other agencies use stigmatizing language when talking about clients (89.5%).
    - A small percentage (16.7%) indicated they heard their co-workers using stigmatizing language sometimes or often.
    - Most indicated that they rarely or never talk about a client/patient in ways they wouldn't if the client was present (94.7%).
    - The majority indicated they often or sometimes speak up if they hear others using stigmatizing language (94.7%).

Recommendations

Based on the results of the community needs assessment, the following recommendations were developed by the project team.

- Service providers and the community should engage in learning opportunities to understand how to use non-stigmatizing language and create more supportive environments when assisting people who use drugs.
- Efforts to engage those working in healthcare settings and police/law enforcement in stigma reduction training should be prioritized.
- More opportunities to educate the community about substance use and overdose should be implemented including public awareness campaigns with door-to-door canvassing and media content.
- Funding should be increased to enhance supports for individuals who use drugs, such as extending service hours to evenings and weekends and creating more service access points.
- Agencies that serve people who use drugs should be encouraged to be more flexible with employee work schedules to create more opportunities for people to access services and supports during evenings and weekends.
- Housing barriers in the community should be addressed and work should be done to understand the specific housing needs of the community, especially barriers that impact people who use drugs.
- The community should be better informed of available housing options and additional options should be developed including, but not limited to, permanent housing programs.
- Safe environments for people who use drugs should be identified.

Introduction

In the United States, drug overdoses are among the leading causes of injury death in adults and have continued to rise over the last three decades (Spencer et al, 2023). According to the Centers for Disease Control and Prevention, in 2022, 108,000 people died from drug overdose in America. In over 60% of the overdose deaths that occurred, there was at least one opportunity for the individual to be linked to care before the overdose, or for life-saving actions to have been implemented when the overdose occurred (CDC, 2024a). In Nevada, reported drug overdose deaths increased by 19.96% between December 2022 and 2023; this number is underreported as data are incomplete (Ahmad et al, 2024). Drug overdose deaths are preventable and while numerous factors contribute to overdose deaths, there are other protective factors, including harm reduction, expanding funding opportunities, and increasing the availability of data that can make a difference in addressing the evolving epidemic (CDC, 2024b). It is important to better understand what is contributing to overdose and what barriers to protective factors exist to address this epidemic.

To better understand the impacts of the overdose epidemic and the needs of the community in Nevada, surveys and community needs assessments have been conducted to gain knowledge of gaps in the state and make recommendations to prevent overdoses. In 2018, Nevada's Division of Public and Behavioral Health conducted a needs assessment aimed directly at better understanding the opioid crisis in Nevada. At the time, the report cited gaps in the availability of naloxone among individuals who are legally prescribed opioid pain medication due to the lack of co-prescriptions for naloxone and opioids by healthcare providers (Nevada Division of Public and Behavioral Health, 2018). The needs assessment also reported limited recovery supports in the state and a lack of connections between the levels of care in coordinated care management. In 2022, the State of Nevada, in partnership with Mercer, conducted another needs assessment to further understand the opioid crisis in Nevada (State of Nevada, 2022). In this needs assessment, it was found that Nevada had a lack of unified statewide prevention programming, including housing, needle exchanges, transportation, employment support, and educational support for people in recovery, leading to gaps in care (State of Nevada, 2022). The needs assessment also included two qualitative studies conducted in the state in which current and former opioid users indicated they need additional harm reduction supports in the state and more "consistent outreach into encampment communities." (State of Nevada, 2022).

In 2021, Nevada Institute for Children's Research and Policy (NICRP), in collaboration with the Southern Nevada Health District (SNHD), conducted a survey in Clark County, Nevada, to understand the adult public perception of drug use, the availability of harm reduction services, such as naloxone and needle exchange programs, and other existing harm reduction strategies (Nevada Institute for Children's Research and Policy, 2021). In the survey, participants were asked to offer recommendations and suggestions for preventing overdoses and drug misuse in the community. Some of the things participants recommended include increasing access to preventative resources for those in need, increasing harm reduction supports, including needle exchange programs and naloxone availability, and increasing the availability of treatment programs that are affordable or free for those who use drugs (Nevada Institute for Children's Research and Policy, 2021). Lastly, in 2022, the Nevada Minority Health and Equity Coalition (NMHEC) and NICRP launched a project to further understand the experiences of those who have used opioids, those in recovery, and of loved ones of people who use drugs (NMHEC et al, 2022). Recommendations from this project included increasing awareness of harm reduction strategies, improving access to treatment for individuals who use drugs, increasing efforts to improve

transportation services, improving housing, and continuing to improve efforts to reduce stigma around those who use opioids (NMHEC et al, 2022). From these surveys and needs assessments, it is clear it is important to continue understanding how to prevent overdoses and to better understand how to increase access to services and supports for people who use drugs to prevent overdoses in the community.

Purpose of the Current Needs Assessment

NICRP, in collaboration with SNHD, conducted the current needs assessment to better understand the barriers to overdose prevention in Clark County, Nevada, and to provide recommendations for addressing the contributors to overdose.

Methodology

Project Team

To facilitate the community needs assessment process, SNHD and NICRP assembled a project team consisting of researchers, community partners, and individuals impacted by overdose. The primary goal of the project team was to contribute to the development of the goals and objectives of the community needs assessment, provide feedback on the tools to be used, and assist in interpreting the results of the community needs assessment. NICRP and SNHD reached out to potential project team members and invited them to participate via email. Ultimately, 21 community members agreed to be part of the project team.

Identification of Priorities

In November 2023, the project team was brought together for an in-person meeting to identify the priorities of the community needs assessment; nine project team members were able to attend. During the meeting, the team participated in an activity developed by NICRP. The activity asked members to work independently to: 1) Identify the top five barriers/gaps in the community causing/worsening overdose in the community and 2) Identify the top five facilitators of overdose prevention (things that are working) in the community. Next, members were asked to work in small groups to come to a consensus on the top five barriers/gaps and the top five facilitators. When the groups had completed the task, each reported out their barriers/gaps and facilitators and then the team as a whole worked to rank order both lists. To include input from all project team members, following the meeting, NICRP sent a follow-up survey to all members presenting them with the barriers/gaps and facilitators and asked them to rank order them. In addition, they were asked who they would recommend engaging for insight into their top choices. Twenty team members participated in the survey and the results indicated that the community needs assessment should examine the systemic barriers that contribute to overdose, including stigma, poor transportation, and lack of housing, funding, and data sharing, and the facilitators of overdose prevention including the availability of naloxone, test strips, and drug supply testing. Community partners and people who use drugs were identified as those who should be engaged to learn more about these topics.

Instrument Development

Based on the project team's identified priorities, NICRP conducted a comprehensive review of previous needs assessments and surveys related to overdose prevention to help inform the development of the instruments for the community needs assessment. Using this process, NICRP drafted a set of questions for people who use drugs and a set of questions for organizations that serve this demographic. Next,

NICRP and SNHD collaborated to revise and streamline both instruments which resulted in a survey for people who use drugs and an interview for community partners. Once a draft of the survey and the interview were agreed upon, NICRP sent the instruments to the project team members for feedback. After incorporating the team's feedback, the instruments underwent a final review by SNHD and were approved in March 2024. A brief description of both instruments follows and full copies are available in the appendices.

Survey for People Who Use Drugs – The Survey for People Who Use Drugs consisted of 20 questions aimed at understanding the barriers to overdose prevention. The survey included questions about access to harm reduction services and supplies, transportation, housing, and stigma. The survey was available in both paper and electronic formats and was designed to take no more than 10 minutes for an individual to complete. Participants were informed that completion of the survey was voluntary, their responses would be kept confidential, and they had to be 18 years or older to take part in the survey.

Community Partner Interview – The Community Partner Interview consisted of 15 questions designed to understand the barriers to overdose prevention from the service perspective. The interview included questions about funding, data sharing, and stigma. The interview was designed to be completed over the phone within 15 minutes. Participants were informed that their participation was voluntary and that their responses would be kept confidential.

Data Collection

Below are descriptions of how data were collected for both instruments used in the current community needs assessment.

Survey for People Who Use Drugs – To recruit survey participants, SNHD reached out to its internal Linkage to Action (L2A) team and the other project partners responsible for providing direct services through the Overdose Data to Action grant. SNHD coordinated with these partners to visit their locations and have the surveys administered in person, either during scheduled service hours or at pre-organized events. All sites elected to have their clients complete the paper survey as opposed to the electronic version. SNHD kept detailed records of the date, location, and number of surveys completed during each administration. Upon completion of survey administration, SNHD provided NICRP with the records and completed surveys for data entry and analysis.

Community Partner Interview – To recruit interview participants, SNHD provided NICRP with the email addresses of 19 community partners. NICRP emailed each of the partners inviting them to participate to which eight agreed. NICRP coordinated the scheduling of the interviews directly with the partners via email. Each interview was scheduled for 15 minutes via phone. Interview responses were manually entered directly into Qualtrics while the interview was conducted. Upon completion of the interview, while still on the phone, participants were asked to identify other individuals within their organization or in the community who would be interested in participating in the interview. Community partners suggested 13 additional individuals to recruit for the interview. NICRP attempted to contact these individuals and was able to complete interviews with 11 of them.

Data Analysis

The responses to the Survey for People Who Use Drugs were manually entered into Qualtrics by a member of the NICRP team. Subsequently, NICRP conducted a quality assurance and control check of the physical client surveys entered into Qualtrics before proceeding with data analysis. After the quality

assurance and control checks, the client survey and partner interview data were exported into the Statistical Package for the Social Sciences (SPSS) for analysis.

Results

The results of the Survey for People Who Use Drugs and the Community Partner Interview follow, after which, recommendations based on the results of both are provided.

Survey for People Who Use Drugs

Demographics – There were 171 survey respondents. However, the first question on the survey asked, "Would you describe yourself as having lived experience with drug use?" Of the 171 respondents, 16 indicated that they did not have lived experience, were not sure, or preferred not to answer the question. Therefore, these 16 respondents were excluded from the analyses. The results presented represent those of the remaining 155 respondents.

Table 1 provides the demographics for the 155 respondents included in the analyses of the survey. Most respondents identified as male (65.2%), were between the ages of 31-50 (60.0%), identified as White/Caucasian (41.3%), and had a high school diploma/GED or attended some college (68.4%). When asked if they have had enough money in the past 12 months to cover expenses, the largest percentage of respondents (31.6%) indicated 'sometimes' with the next largest percentage indicating they 'rarely' had enough money (26.5%).

Table 1. Survey respondent demographics (n = 155)

Gender	
Male	65.2% (101)
Female	32.9% (51)
Genderqueer/Gender-nonconforming	0.0% (0)
Transgender	0.0% (0)
Gender not listed	0.0% (0)
Prefer not to answer	0.0% (0)
Missing	1.9% (3)
Total	100% (155)
Age	
20-30	8.4% (13)
31-40	29.7% (46)
41-50	30.3% (47)
51-60	21.3% (33)
61 and older	9.0% (14)
Missing	1.3% (2)
Total	100% (155)

Table 1. (continued)

Race/Ethnicity	
White/Caucasian	41.3% (64)
Multiple Races/Ethnicities	19.4% (30)
Hispanic/Latinx	16.1% (25)
Black/African American	14.8% (23)
American Indian or Alaska Native	1.9% (3)
Native Hawaiian/Pacific Islander	0.7% (1)
Asian	0.0% (0)
Other	2.6% (4)
Prefer not to answer	1.3% (2)
Missing	1.9% (3)
Total	100% (155)
Education	
Less than high school	16.8% (26)
High school diploma	36.1% (56)
Some college	32.3% (50)
Bachelor's Degree (eg.BA or BS)	6.5% (10)
Graduate Degree	0.7% (1)
Prefer not to answer	2.6% (4)
Missing	5.2% (8)
Total	100% (155)
In the past 12 months, I have had enough money to cover my expenses.	
Always	11.6% (18)
Very often	8.4% (13)
Sometimes	31.6% (49)
Rarely	26.5% (41)
Never	14.8% (23)
Prefer not to answer	4.5% (7)
Missing	2.6% (4)
Total	100% (155)

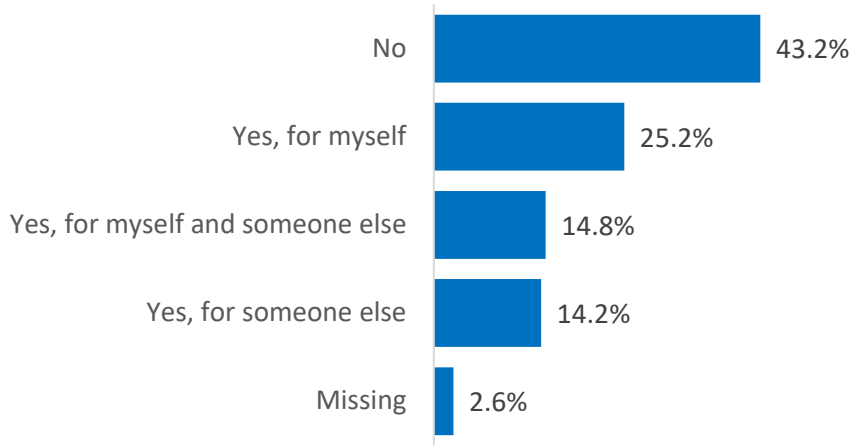
As seen in Table 2, the largest percentage of respondents were recruited for the survey at The Center (28.4%) and at Foundation for Recovery (27.1%).

Table 2. Percent and number of respondents recruited from each location (n = 155)

The Center	28.4% (44)
Foundation for Recovery	27.1% (42)
SNHD Linkage to Action Outreach	19.4% (30)
Trac-B/Impact Exchange	19.4% (30)
EMPOWERED (Roseman)	5.8% (9)
Total	100% (155)

Harm reduction services – The first set of questions on the survey asked respondents about their experiences with harm reduction services. Specifically, the first question asked if they had tried accessing harm reduction services in the past and for whom they accessed services. The following examples of harm reduction services were provided to respondents: syringe exchange, test strips, Narcan/naloxone, and drug supply testing. As seen in Figure 1, the largest percentage of respondents indicated that they had not accessed harm reduction services in the past (43.2%), followed by those that had accessed services for themselves (25.2%), or themselves and someone else (14.8%).

Figure 1. Percent of respondents that tried accessing harm reduction services in the past and for whom (n = 155)



The next question asked respondents to indicate their familiarity with specific harm reduction services, including syringe exchange, test strips, Narcan/naloxone, and drug supply testing. For each service, respondents were asked to indicate if they use or have used the service, if they had heard of it and if they were interested in learning more about it. Narcan/naloxone was the service used the most by respondents (50.3%), followed by syringe exchange (43.9%). The service heard of most by respondents was test strips (36.1%) and the service that respondents were most interested in learning more about was drug supply testing (31.6%), followed by test strips (30.3%). See Table 3.

Table 3. Familiarity and interest in harm reduction services in the community (n = 155)

	Syringe exchange	Test strips	Narcan/ naloxone	Drug supply testing
I use/have used this service	43.9% (68)	34.8% (54)	50.3% (78)	34.2% (53)
I have heard of this service and I'm interested in learning more about it	12.9% (20)	21.9% (34)	18.7% (29)	17.4% (27)
I have heard of this service but I'm not interested in learning more about it	13.6% (21)	14.2% (22)	12.9% (20)	11.6% (18)
I have never heard of this service but I'm interested in learning more about it	5.8% (9)	8.4% (13)	1.9% (3)	14.2% (22)
I have never heard of this service and I'm not interested in learning more about it	14.2% (22)	13.6% (21)	9.7% (15)	14.2% (22)
Missing	9.7% (15)	7.1% (11)	6.5% (10)	8.4% (13)
Total	100% (155)	100% (155)	100% (155)	100% (155)

The next question asked respondents to rate, on a scale from 'strongly disagree' to 'strongly agree,' how much they agreed with statements about accessing harm reduction services and supplies in the community. Overall, most respondents agreed or strongly agreed that they were aware of how to access syringe exchange services (74.8%), test strips (69.7%), and Narcan/naloxone (80.6%). In addition to this, the majority of participants agreed or strongly agreed that harm reduction services and supplies are important tools to decrease overdose (91.6%) and disagreed or strongly disagreed that they feel uncomfortable accessing harm reduction services or supplies because of stigma surrounding people who use drugs (68.4%). See Table 4.

Table 4. The percent and number of respondents that strongly agreed/agreed and strongly disagreed/disagreed with each of the following statements about harm reduction supplies and services in the community (n = 155)

	Strongly Agree/ Agree	Strongly Disagree/ Disagree	Missing	Total
I am aware of how to access syringe exchange services.	74.8% (116)	23.2% (36)	1.9% (3)	100% (155)
I am aware of how to access test strips.	69.7% (108)	30.3% (47)	0.0% (0)	100% (155)
I am aware of how to access Narcan/naloxone.	80.7% (125)	16.8% (26)	2.6% (4)	100% (155)
Harm reduction services/supplies are important tools to decrease overdose.	91.6% (142)	6.5% (10)	1.9% (3)	100% (155)
I feel uncomfortable accessing harm reduction services/supplies because of stigma surrounding people who use drugs.	29.0% (45)	68.4% (106)	2.6% (4)	100% (155)

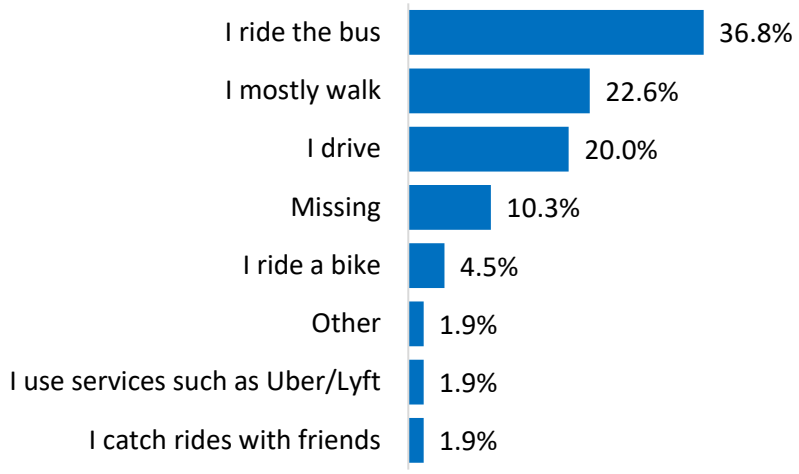
Next, respondents were asked to rate, on a scale of 'very easy' to 'very difficult,' how easy or difficult it was to access the harm reduction services that they use. Overall, the majority of respondents indicated that the services they use are easy or very easy to access. Specifically, 88.7% who use syringe exchange services, 82.8% who use test strips, and 83.5% who use Narcan/naloxone indicated they are easy or very easy to access.

When asked, the majority of respondents (62.0%) indicated that they have access to enough resources, supports, and/or services to be healthy and safe in their community; 17.4% of respondents indicated that they did not, and 20.6% of respondents were not sure or did not respond to the question. Respondents who indicated that they did not have access to enough resources, supports, and/or services were asked what they would like to be able to access in the community that they cannot. Of the 20 respondents who provided an answer, the most to least common themes included:

- Housing and help with finding resources for housing,
- Better access to harm reduction supplies, such as naloxone and syringes,
- Better access to harm reduction services, including having service during the evenings and on the weekends, and
- Better services to assist with recovery, such as longer detox sessions and help with initiating recovery.

Transportation – The next section of the survey asked respondents about their experiences utilizing transportation to access harm reduction services and supplies. The first question in this section asked respondents to identify their main form of transportation from a list. As seen in Figure 2, the largest percentage of respondents indicated that they ride the bus (36.8%), followed by those who walk as their main form of transportation (22.6%).

Figure 2. Respondents' main form of transportation (n = 155)



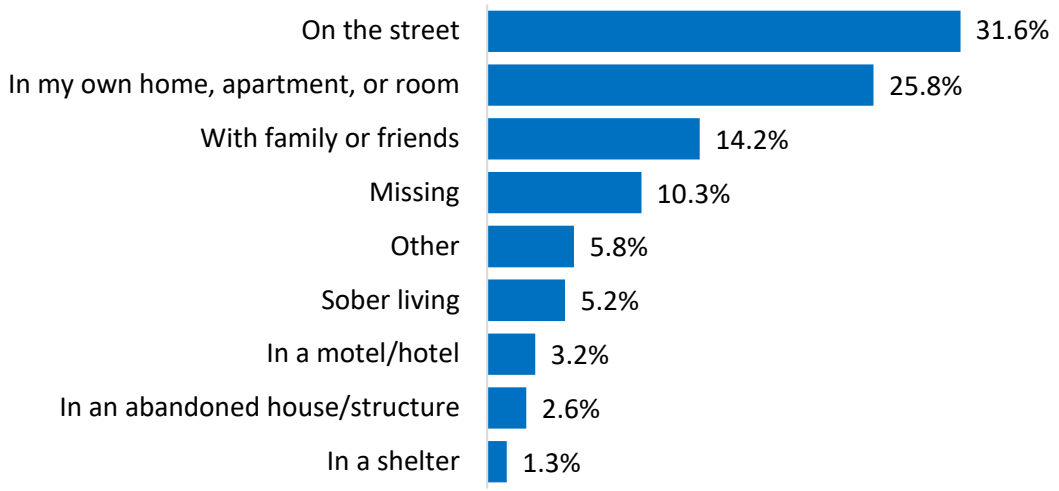
Next, respondents were asked how much they agreed or disagreed that transportation is a barrier to accessing harm reduction services. More than half (52.9%) of respondents disagreed or strongly disagreed that transportation was a barrier. Those who strongly disagreed that transportation was a barrier (19.4%) were instructed to skip the next question which asked respondents if they would be more likely to access harm reduction services if they were provided with bus passes and what changes

to public transportation would help them better access harm reduction services. The majority (82.5%) of respondents answering this question indicated that they agreed or strongly agreed that they would be more likely to access harm reduction services if provided with bus passes. In addition to bus passes, 51 respondents indicated that the following would better help them access harm reduction services:

- Rideshare vouchers,
- Reduced transit fares,
- Provision of paper schedules,
- Clear pricing for riding the bus, and
- Shorter wait times for buses.

Housing – The next section of the survey was designed to understand the current housing situation of the respondents. The first question asked respondents to indicate, from a list, where they currently spend their nights. As seen in Figure 3, the largest percentage of respondents indicated that they spend their nights on the street (31.6%), followed by those that live in their own home, apartment, or room (25.8%). There were seventeen respondents that selected 'other' and of these, eight wrote in 'sober living', therefore, although not a survey response option, it is included in Figure 3. 'Other' responses (5.8%) written in by respondents included car/truck, halfway house, and treatment program.

Figure 3. Where respondents spend their nights (n = 155)



Next, respondents were asked to describe their current housing situation on a scale of 'very unstable' to 'very stable' and indicate their level of satisfaction with it from 'very satisfied' to 'very unsatisfied.' More than half (56.8%) of respondents indicated that their current housing situation was unstable or very unstable with almost two-thirds (65.8%) of respondents indicating that they were unsatisfied or very unsatisfied with their current housing situation.

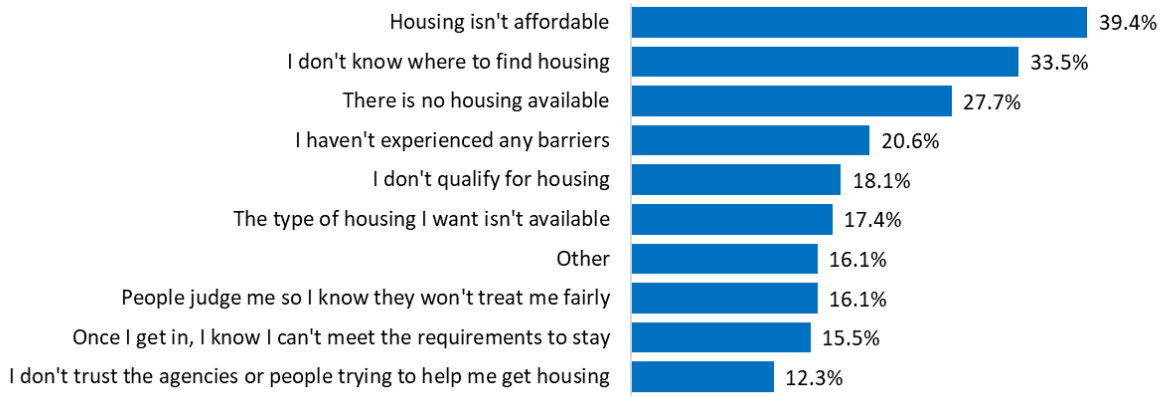
Respondents were then asked to rate on a scale of 'strongly disagree' to 'strongly agree' how much they agreed or disagreed with a series of statements about their experiences with housing in the community. As shown in Table 5, more than half of respondents (56.8%) indicated that they are aware of housing resources available in the community, they do not have trouble accessing housing due to their substance use (53.5%), and they have not been evicted from housing due to their substance use (70.3%).

Table 5. The percent and number of respondents that strongly agreed/agreed and strongly disagreed/disagreed with each of the following statements about housing (n = 155)

	Strongly Agree/ Agree	Strongly Disagree/ Disagree	Missing	Total
I am aware of housing resources that are currently available in my community.	56.8% (88)	38.7% (60)	4.5% (7)	100% (155)
I have/had trouble accessing housing due to my substance use.	42.6% (66)	53.6% (83)	3.9% (6)	100% (155)
I have previously been evicted from housing due to my substance use.	25.2% (39)	70.3% (109)	4.5% (7)	100% (155)

The final item in this section of the survey asked respondents to select from a list, all of the barriers they have experienced when trying to access housing. As shown in Figure 4, respondents most often indicated 'housing isn't affordable' (18.2%), followed by 'I don't know where to find housing' (15.5%), and 'there is no housing available' (12.8%). 'Other' barriers to accessing housing (7.4%) written in by respondents included waitlists, transportation, criminal background, lack of assistance in getting housing, pride, and discrimination.

Figure 4. The percent of respondents indicating that each of the following has been a barrier experienced when trying to access housing (n = 155)



Stigma – The last section of the survey asked respondents about their experience with stigma and discrimination in the community. First, respondents were asked how welcome they feel at medical provider's offices and at service agencies in the community. Specifically, respondents were asked to indicate how much they agreed or disagreed with the following statements: "I do not feel welcome at the doctor's/medical provider's office" and "I do not feel welcome at service agencies in the community." Overall, respondents indicated that they feel welcome at doctor's/medical provider's offices and at service agencies in the community with almost two-thirds (65.8%) of respondents disagreeing or strongly disagreeing that they did not feel welcome at the doctor's/medical provider's

office and almost two-thirds (65.8%) disagreeing or strongly disagreeing that they did not feel welcome at service agencies in the community.

The next question in this section of the survey asked respondents, "Have you ever been treated differently or experienced stigma or discrimination as a result of your substance use?" Most respondents answered 'yes' to this question (59.4%). For respondents who answered yes, they were asked to select from a list, where interactions with stigma and discrimination took place and if they were comfortable, to answer an open-ended question describing some of the experiences. Of the 220 responses given to 'if yes, where or with whom have these interactions taken place?', most of these interactions were 'with police/law enforcement' (24.6%), followed by 19.6% occurring 'in a healthcare setting.' See Table 6.

Table 6. Experiences of stigma and discrimination in the community

Have you ever been treated differently or experienced stigma or discrimination as a result of your substance use?	
Yes	59.4% (92)
No	25.8% (40)
I'm not sure	10.3% (16)
Missing	4.5% (7)
Total	100% (155)
If yes, where or with whom have these interactions taken place? (Note: Respondents were instructed to select all that apply.)	
With police/law enforcement	24.6% (54)
In a healthcare setting	19.6% (43)
With the legal system/in court	17.3% (38)
When trying to get housing	14.1% (31)
With treatment providers	13.2% (29)
With recovery service providers	9.1% (20)
With harm reduction service providers	2.3% (5)
Total	100% (220)

There were 31 respondents who described their interactions in which they were treated differently or experienced stigma or discrimination. The most common themes of these responses, from most to least common, included the following:

- Doctors being dismissive and not providing them with healthcare services because of their drug use,
- Being treated wrongly or unfairly by police/law enforcement due to prejudice,
- An overall sense of feeling belittled or shamed in the community, and
- Being discriminated against because of their appearance.

The last two questions in this section asked respondents if they currently use or used in the past, what do/did they need to use more safely and what would make it easier to access these things. In response to what they would need to use more safely, the most common themes from the 59 responses, from most to least common, included the following:

- A home or a safe environment to be in,
- Harm reduction supplies, such as clean syringes, test strips, or Narcan/naloxone, and
- Greater access to information, such as housing resources and mental health services.

In response to what would make it easier to access the things needed to use more safely, 70 respondents indicated they need or needed:

- Access to reliable transportation,
- More harm reduction or needle exchange sites,
- Additional funds,
- Better programming, and
- Better information sharing about resources in the community.

Community Partner Interview

Demographics – Table 7 provides the demographics for the 19 respondents who participated in the Community Partner Interview. The largest percentage of respondents identified as female (68.4%), were between the ages of 25-45 (79.0%), identified as White/Caucasian (47.4%), and had attended some college (42.1%). Organizational demographics showed most respondents had been at their organization for 3-5 years (42.1%), work in the field of harm reduction (21.4%), and work at a non-profit that provides direct service (52.2%). A list of the agencies with which the participants are affiliated is provided in Appendix C.

Table 7. Interview respondent demographics

Gender	
Male	26.3% (5)
Female	68.4% (13)
Genderqueer/Gender-nonconforming	0.0% (0)
Transgender	0.0% (0)
Gender not listed: Non-binary	5.3% (1)
Prefer not to answer	0.0% (0)
Total	100% (19)
Age	
25-35	42.1% (8)
36-45	36.8% (7)
46-55	5.3% (1)
56 and over	15.8% (3)
Prefer not to answer	0.0% (0)
Total	100% (19)

Table 7. (continued)

Race/Ethnicity	
American Indian or Alaska Native	0.0% (0)
Asian	0.0% (0)
Black/African American	21.1% (4)
Hispanic/Latinx	10.5% (2)
Native Hawaiian/Pacific Islander	0.0% (0)
White/Caucasian	47.4% (9)
Other	5.3% (1)
Multiple Races/Ethnicities	15.8% (3)
Total	100% (19)
Education	
Less than high school	0.0% (0)
High school diploma	5.3% (1)
Some college	42.1% (8)
Bachelor's Degree (eg.BA or BS)	26.3% (5)
Graduate Degree	26.3% (5)
Prefer not to answer	0.0% (0)
Total	100% (19)
Length of time at organization	
Less than a year	21.1% (4)
1-2 years	21.1% (4)
3-5 years	42.1% (8)
6-9 years	10.5% (2)
10-15 years	5.3% (1)
More than 15 years	0.0% (0)
Total	100% (19)
Field of Work (Note: Respondents were instructed to select all that apply.)	
Harm reduction	21.4% (18)
Prevention	20.2% (17)
Peer support	19.1% (16)
Recovery services	17.9% (15)
Substance use treatment	11.9% (10)
Housing	6.0% (5)
Other: Clinical Services & Mental Health Therapy SURG/Prevention Committee Rescue	3.6% (3)
Law enforcement	0.0% (0)
First responder	0.0% (0)
Total	100% (84)

Table 7. (continued)

Type of Organization (Note: Respondents were instructed to select all that apply.)	
Non-profit direct service	52.2% (12)
Non-profit other	30.4% (7)
State government	4.4% (1)
For-profit direct service	4.4% (1)
For-profit other	4.4% (1)
Other: Self-Employed	4.4% (1)
County government	0.0% (0)
Total	100% (23)

Overdose contributors – The first interview question asked respondents to rate how much they believe nine different items contribute to overdose in Clark County on a scale from 'not at all' to 'to a great extent'. As seen in Table 8, according to the respondents, an unsafe drug supply (94.7%), lack of housing (89.5%), and stigma (89.5%) contribute to overdose in the community to a great extent.

Table 8. Respondent ratings of how much each item listed contributes to overdose in the community (n = 19)

	To a great extent	Somewhat	Very little	Not at all	Total
Unsafe drug supply	94.7% (18)	5.3% (1)	0.0% (0)	0.0% (0)	100% (19)
Lack of housing	89.5% (17)	10.5% (2)	0.0% (0)	0.0% (0)	100% (19)
Stigma	89.5% (17)	10.5% (2)	0.0% (0)	0.0% (0)	100% (19)
Lack of funding*	72.2% (13)	22.2% (4)	5.6% (1)	0.0% (0)	100% (18)
Lack of evidence-based primary prevention programs in PreK-12 education*	50.0% (9)	22.2% (4)	27.8% (5)	0.0% (0)	100% (18)
Lack of transportation	42.1% (8)	42.1% (8)	10.5% (2)	5.3% (1)	100% (19)
Insufficient access to harm reduction services	42.1% (8)	52.6% (10)	5.3% (1)	0.0% (0)	100% (19)
Poor care coordination between service providers	36.8% (7)	47.4% (9)	10.5% (2)	5.3% (1)	100% (19)
Lack of data sharing	31.6% (6)	31.6% (6)	31.6% (6)	5.3% (1)	100% (19)
**For these items, n = 18*					

Funding – The next set of interview questions asked respondents about their experiences in obtaining funding to provide community services. The first question asked respondents to identify how their organization is funded. Most respondents (33.3%) indicated that their organization is self-supported through grant funding. In-kind donations (22.9%) were the second most popular funding source (see Table 9). Respondents who selected 'other' explained that they were not currently funded or were under contract with different organizations.

Table 9. Funding sources for respondents' agencies

Self-supported through grant funding	33.3% (16)
In-kind donations	22.9% (11)
Government funded	20.8% (10)
Privately funded	12.5% (6)
Other	10.4% (5)
Total	100% (48)
Note: Respondents were instructed to select all that apply.	

The next question in this section asked respondents to rate how easy or difficult it is to access funding to support their work on a scale from 'very easy' to 'very difficult.' Of those who indicated that their organization is self-supported, the majority of respondents indicated that it is difficult or very difficult to access funding to support the work they do in the community (86.7%). Next, respondents were asked how much they agreed or disagreed that there are not enough funding opportunities available to support the work they do in the community; all but one respondent (94.7%) agreed or strongly agreed with this statement.

The next interview question asked respondents to indicate whether or not they had applied for funding related to overdose and/or harm reduction in the past 5 years. More than half (57.9%) of respondents indicated that they had applied for funding in the last 5 years, while 31.6% had not, and 10.5% indicated they were unsure.

Respondents who indicated they had applied for funding in the past 5 years were asked two additional questions: "For funding you applied for and received in this area in the past 5 years, why do you think you received it/what were your strengths?" and "For funding you applied for and didn't receive in this area in the past 5 years, why do you think you didn't receive it/what were your weaknesses?" When discussing the strengths of funding received, respondents commonly cited they received funding because:

- Their organization has unique qualities, including serving and understanding the needs of specialized populations,
- Staff at their organizations have lived experiences, and
- Their organization demonstrated utilization of evidence-based practices in their work.

When discussing funding that was not received, respondents frequently mentioned:

- The lack of funding streams for harm reduction work overall and
- Grant funding in this area is very competitive and hard to secure.

Respondents who indicated they had not applied for funding in the past 5 years were asked, "What are the reasons why you haven't applied for funding?" The majority of respondents did not apply for funding as it was not part of their current role within their organization.

Regardless of whether they applied for funding, all respondents were asked to discuss the barriers they encounter when seeking support for their work. Below are the most common themes listed from most to least common.

- Competition for funding
- Grant requirements can be difficult, including the turnaround time to submit grants and grant application guidelines
- Continued stigma around the topic of harm reduction
- Overall lack of resources and data to support grant writing

Data and data sharing – The next set of questions asked about experiences with data and data sharing. The first question in this section asked respondents if they collect data that they believe other organizations in the community would find useful to their work; 89.5% of respondents indicated that they do. Next, respondents were asked if they had shared data with other organizations and if so, how did they share it and what the intent of sharing it was. Most respondents indicated they do share data with other organizations through presentations and shared reports and offered various reasons for sharing data with the community, including reporting on organizational successes, sharing data with grantors, highlighting the needs of people who use drugs, and identifying gaps and barriers among this group in the community.

Next, respondents were asked what type of data they would like to see collected or shared with them and/or their organization and how they would use that data in their work. Responses from most to least common are listed below.

- More disaggregated overdose data is needed, including data for specific demographics and the locations of overdoses in the community
- Real-time data
- Information about what specific substances are being used and where in the community they are being used
- Specific locations where organizations are providing services in the community to avoid duplicative efforts
- Data about harm reduction successes among organizations in the community

Next, respondents were asked what would make data sharing among organizations in the community easier. The vast majority of respondents indicated that a centralized HIPAA-secured data system is needed for organizations to safely and securely share data about clients and identify where service gaps exist; respondents also indicated that these data should be standardized.

Stigma – In the final section of the interview, respondents were asked about their experiences with the use of stigmatizing language. They were asked to rate, on a scale from ‘never’ to ‘often,’ how frequently they experienced specific occurrences. Table 10 provides respondents' responses to each occurrence. Overall, respondents reported having heard other agencies use stigmatizing language when talking about clients/patients more often than their co-workers. Specifically, 89.5% reported they have sometimes or often heard other agencies use stigmatizing language when talking about clients whereas 16.7% reported hearing their co-workers use stigmatizing language sometimes or often. Most respondents indicated that they rarely or never talk about a client/patient in ways they wouldn’t if the client was present (94.7%) and will often or sometimes speak up if they hear others using stigmatizing language (94.7%).

Table 10. The percent and number of respondents that indicated that they often/sometimes and rarely/never experience the items listed (n = 19)

	Often/ Sometimes	Rarely/Never	Total
I have heard other agencies use stigmatizing language when talking about clients/patients.	89.5% (17)	10.5% (2)	100% (19)
I have heard other agencies use stigmatizing language when talking to clients/patients. *	72.2% (13)	27.8% (5)	100% (18)
I have heard co-workers use stigmatizing language when talking about clients/patients. *	16.7% (3)	83.3% (15)	100% (18)
I have heard co-workers use stigmatizing language when talking to clients/patients.	10.5% (2)	89.5% (17)	100% (19)
I have talked about a client/patient in ways that I wouldn't if they were present.	5.3% (1)	94.7% (18)	100% (19)
I have spoken up when I have heard others use stigmatizing language.	94.7% (18)	5.3% (1)	100% (19)
**For these items, n = 18*			

Recommendations

After completion of data analysis, NICRP convened a meeting with the project team to discuss the results. NICRP presented selections of the results and asked the project team to discuss what surprised them about the data, what interested them about the data, and to provide recommendations to address barriers to overdose prevention based on the data presented. Project team members expressed they were surprised to learn partners who serve people who use drugs were using stigmatizing language, were interested in the services people who use drugs had and had not heard of, and were surprised and saddened to learn about the housing situations of people who use drugs and how many were experiencing stigma in the presence of police/law enforcement and in healthcare settings. Based on the results of the community needs assessment, the project team provided recommendations as follows:

- Service providers and the community should engage in learning opportunities to understand how to use non-stigmatizing language and create more supportive environments when assisting people who use drugs.
- Efforts to engage those working in healthcare settings and police/law enforcement in stigma reduction training should be prioritized.
- More opportunities to educate the community about substance use and overdose should be implemented including public awareness campaigns with door-to-door canvassing and media content.
- Funding should be increased to enhance supports for individuals who use drugs, such as extending service hours to evenings and weekends and creating more service access points.
- Agencies that serve people who use drugs should be encouraged to be more flexible with employee work schedules to create more opportunities for people to access services and supports during evenings and weekends.

- Housing barriers in the community should be addressed and work should be done to understand the specific housing needs of the community, especially barriers that impact people who use drugs.
- The community should be better informed of available housing options and additional options should be developed including, but not limited to, permanent housing programs.
- Safe environments for people who use drugs should be identified.

In addition, it is recommended that more awareness be brought to the harm reduction services of drug supply testing and test strips which were the least heard of by the survey participants. It is also suggested that service providers procure or offer to print bus schedules for clients and advocate for reduced and more transparent bus fare pricing.

Limitations

While this needs assessment offers valuable insight into overdose prevention, certain limitations must be noted. First, the majority of those who completed the Survey for People Who Use Drugs were recruited by project partner agencies. Therefore, they are more likely to be aware of and to have used harm reduction services than other people who use drugs in the community. They might also be better connected to services in general. Also, with regard to the Survey for People Who Use Drugs, no transgender, genderqueer, or gender-nonconforming individuals participated which limits our understanding of their experiences and needs. In the future, intentional effort should be made to reach out to and include these individuals so that they can be better served. Finally, the majority of those who participated in the Community Partner Interview are current project partners and are not likely representative of all of those providing services to people who use drugs in the community.

Conclusions

This needs assessment provides insights into the next steps in addressing overdose in Clark County. Supported by the findings of previous needs assessments and surveys that have been conducted in Clark County and Nevada as a whole, this needs assessment reveals there remain barriers to overdose prevention, including the continued stigma toward people who use drugs, lack of access to safe and stable housing, and limited access to resources during non-traditional service hours. Additionally, by interviewing partners in the community who serve people who use drugs, it is clear that additional funding supports for community-serving organizations is needed to expand services for people who use drugs and additional training is needed to address awareness of self-stigma to better provide safe and inclusive community spaces. These findings can serve as the basis for the development of targeted interventions and strategies aimed at addressing identified gaps and barriers that exist within the community. The engagement of community partners and individuals impacted by overdose will continue to be crucial in the implementation of evidence-based solutions. Collaboration, ongoing communication, and a commitment to inclusivity and equity will be pivotal in ensuring the successful execution of initiatives aimed at reducing overdose and improving community well-being.

References

Ahmad FB, Cisewski JA, Rossen LM, Sutton P. *Provisional drug overdose death counts*. National Center for Health Statistics. 2024.

Centers for Disease Control and Prevention. (2024a). *Overdose Prevention: What the CDC is Doing.* https://www.cdc.gov/overdose-prevention/about/what-cdc-is-doing.html

Centers for Disease Control and Prevention. (2024b). *Overdose Prevention: About Overdose Prevention.* https://www.cdc.gov/overdose-prevention/about/index.html

Nevada Division of Public and Behavioral Health. (2018). Nevada Opioid Crisis Needs Assessment. In *nevadaopioidresponse.org*. Retrieved May 29, 2024, from https://nvopioidresponse.org/wp-content/uploads/2020/01/nevada-opioid-crisis-needs-assessment-3.21.19.pdf

Nevada Institute for Children's Research and Policy. (2020). 2020 Clark County Community Perceptions of Drug Use and Harm Reduction Survey Report.

Nevada Minority Health and Equity Coalition & Nevada Institute for Children's Research and Policy. (2022). Voices of the Opioid Epidemic: Perspectives of Those with Lived Experience in Nevada. In nic.unlv.edu. Retrieved May 29, 2024, from https://nic.unlv.edu/wp-content/uploads/2023/03/Voices-of-the-Opioid-Epidemic_FinalReport_4.25.22.pdf

Spencer, M., Garnett, M., & Miniño, A. (2023). *Drug Overdose Deaths in the United States, 2002-2022*. https://doi.org/10.15620/cdc:135849

State of Nevada. (2022). Nevada Resiliency Fund: Opioid Needs Assessment. In https://dhhs.nv.gov/. Retrieved May 29, 2024, from https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Advisory_Committees/ACRN/NV_Needs%20Assessment%20Report%20DRAFT%20for%20ACRN%202022%2004%2009(2).pdf

Appendix A: Survey for People Who Use Drugs

Community Needs Assessment Survey

Clients and Outreach Participants

Thank you for taking the time to complete this survey!

The Southern Nevada Health District and Nevada Institute for Children's Research and Policy at UNLV have created this survey to better understand the barriers to overdose prevention in the community. Your survey responses will be used to assess and improve harm reduction services in Clark County. Your feedback is greatly appreciated!

Important things to know:

- This survey should take no longer than 10 minutes to complete
- Your responses will be kept confidential
- Your name will not be associated with your responses
- No reference will be made in written or oral materials that would link you to your responses
- Your participation is voluntary
- You may choose not to answer any question that you do not feel comfortable answering
- You must be at least 18 years of age to participate

If you have any questions about the survey or how the information will be used, please contact Dawn Davidson or Aaliyah Goodie at Nevada Institute for Children's Research and Policy at (702) 895-1040.

Thank you again for your time and participation!

<u>If you have already taken this survey, please do not complete it again.</u>

1. Would you describe yourself as having lived experience with drug use?			
Yes (Continue to Q2)	No (You can stop taking this survey. Thank you!)	Not sure (You can stop taking this survey. Thank you!)	Prefer not to answer (You can stop taking this survey. Thank you!)

2. Have you tried to access harm reduction services in the past? (For example, syringe exchange, test strips, Narcan/naloxone, or drug supply testing.)			
No	Yes, for myself	Yes, for someone else	Yes, for myself and someone else

The following section is designed to gather information about your knowledge and experience utilizing **harm reduction services**. Please answer the questions truthfully and to the best of your ability.

3. Please indicate how familiar you are with each of the harm reduction services listed below: (Select one response for each service.)					
Syringe exchange	I use/have used this service	I have heard of this service and I'm interested in learning more about it	I have heard of this service but I'm <u>not</u> interested in learning more about it	I have <u>never</u> heard of this service but I'm interested in learning more about it	I have <u>never</u> heard of this service and I'm <u>not</u> interested in learning more about it
Test strips *(To test your drugs for things like fentanyl or xylazine/tranq)*	I use/have used this service	I have heard of this service and I'm interested in learning more about it	I have heard of this service but I'm <u>not</u> interested in learning more about it	I have <u>never</u> heard of this service but I'm interested in learning more about it	I have <u>never</u> heard of this service and I'm <u>not</u> interested in learning more about it
Narcan/naloxone	I use/have used this service	I have heard of this service and I'm interested in learning more about it	I have heard of this service but I'm <u>not</u> interested in learning more about it	I have <u>never</u> heard of this service but I'm interested in learning more about it	I have <u>never</u> heard of this service and I'm <u>not</u> interested in learning more about it
Drug supply testing *(Providing a sample to an agency to determine what it actually contains)*	I use/have used this service	I have heard of this service and I'm interested in learning more about it	I have heard of this service but I'm <u>not</u> interested in learning more about it	I have <u>never</u> heard of this service but I'm interested in learning more about it	I have <u>never</u> heard of this service and I'm <u>not</u> interested in learning more about it

4. Please indicate how much you agree or disagree with each of the following statements:				
I am aware of how to access syringe exchange services.	Strongly disagree	Disagree	Agree	Strongly agree
I am aware of how to access test strips.	Strongly disagree	Disagree	Agree	Strongly agree
I am aware of how to access Narcan/naloxone.	Strongly disagree	Disagree	Agree	Strongly agree
Harm reduction services/supplies are important tools to decrease overdose.	Strongly disagree	Disagree	Agree	Strongly agree
I feel <u>uncomfortable</u> accessing harm reduction services/supplies because of stigma surrounding people who use drugs.	Strongly disagree	Disagree	Agree	Strongly agree

5. If you currently use any of the below harm reduction services, how easy is it for you to access them?					
Syringe exchange	Very easy	Easy	Difficult	Very difficult	I don't use this
Test strips *(To test your drugs for things like fentanyl or xylazine/tranq)*	Very easy	Easy	Difficult	Very difficult	I don't use this
Narcan/naloxone	Very easy	Easy	Difficult	Very difficult	I don't use this

6. As a person who identifies as having lived experience with drug use, do you feel you have access to enough resources, supports and/or services to be healthy and safe in your community?		
Yes (Skip to Q8)	No (Continue to Q7)	I'm not sure (Skip to Q8)
7. If you are comfortable, please tell us what you would like to be able to access but can't.		

This next section is designed to understand your ability to access **transportation**. Please answer the questions truthfully and to the best of your ability.

8. How would you best describe your main form of transportation?			
I ride the bus	I drive	I mostly walk	I ride a bike
I catch rides with friends	I use services such as Uber/Lyft	Other: (Please Describe)	

9. Please indicate how much you agree or disagree with the following statement: *Transportation is a barrier for me to access harm reduction services.*			
Strongly disagree (Skip to Q11)	Disagree	Agree	Strongly agree

10. Please indicate how much you agree or disagree with the following statement: *I would be more likely to access harm reduction services if I were provided with bus passes.*			
Strongly disagree	Disagree	Agree	Strongly agree
What changes to public transportation would help you better access harm reduction services?			

This section is designed to understand your **current housing situation**. Please answer the questions truthfully and to the best of your ability.

11. Where do you currently spend your nights?					
In my own home, apartment, or room	With family or friends	In a shelter	In a motel/hotel	In an abandoned house/structure	On the street
Other (Please describe):					

12. How would you best describe your current housing situation?			
Very unstable	Unstable	Fairly stable	Very stable

13. How satisfied are you with your current housing situation?			
Very Satisfied	Satisfied	Unsatisfied	Very Unsatisfied

14. Please indicate how much you agree or disagree with each of the following statements:				
I am aware of housing resources that are currently available in my community.	Strongly disagree	Disagree	Agree	Strongly agree
I have/had trouble accessing housing due to my substance use.	Strongly disagree	Disagree	Agree	Strongly agree
I have previously been evicted from housing due to my substance use.	Strongly disagree	Disagree	Agree	Strongly agree

15. What barriers do/did you experience when trying to access housing? (Select all that apply.)	
I don't know where to find housing	There is no housing available
The type of housing I want isn't available	Housing isn't affordable
I don't qualify for housing	Once I get in, I know I can't meet the requirements to stay
I don't trust the agencies or people trying to help me get housing	People judge me so I know they won't treat me fairly
I haven't experienced any barriers	Other (Please describe):

The following section is designed to gather information about your experiences with **stigma/discrimination** in the community. Please answer the questions truthfully and to the best of your ability.

16. Please indicate how much you agree or disagree with the following statements:				
I do not feel welcome at the doctor's/medical provider's office.	Strongly disagree	Disagree	Agree	Strongly agree
I do not feel welcome at service agencies in the community.	Strongly disagree	Disagree	Agree	Strongly agree

17. Have you ever been treated differently or experienced stigma or discrimination as a result of your substance use?			
Yes (Continue)	No (Skip to Q18)	I'm not sure (Skip to Q18)	
If yes, where or with whom have these interactions taken place? (Select all that apply)			
With treatment providers	With harm reduction service providers	With recovery service providers	In a healthcare setting
With police/law enforcement	With the legal system/In court	When trying to get housing	
If you're comfortable, please describe some of these interactions or experiences.			

18. If you currently use substances, or when you did use, what do/did you need to use more safely?
19. What would make it easier to access these things?

20. In the past 12 months, I have had enough money to cover my expenses.	Always	Very Often	Sometimes	Rarely	Never	Prefer not to answer

What is your age? _____	Prefer not to answer					
What is your gender?	Male	Genderqueer/Gender-nonconforming			Transgender	
	Female	Gender not listed (please indicate) _____			Prefer not to answer	
Please circle all that apply to you.	American Indian or Alaska Native	Asian		Black/African American	Hispanic/Latinx	
	Native Hawaiian/ Pacific Islander	White/Caucasian		Other	Prefer not to answer	
What is your educational level?	Less than high school	High School Diploma/GED	Some College	Bachelor's Degree (e.g. BA or BS)	Graduate Degree	Prefer not to answer

Thank you for your participation!

Appendix B: Community Partner Interview

Community Needs Assessment

Community Partners

INTERVIEW

Thank you for taking the time to speak to me today!

The Southern Nevada Health District and Nevada Institute for Children's Research and Policy at UNLV have invited you to complete this interview to better understand the barriers to overdose prevention in the community. Your responses will be used to assess and improve harm reduction training and services in Clark County. Your feedback is greatly appreciated!

This interview should take no longer than 15 minutes to complete. Your responses will be kept confidential, your name will not be associated with your responses, and no reference will be made in written or oral materials that would link you to your responses. Your participation is voluntary, and you may choose not to answer any question that you do not feel comfortable answering.

If, at any point during this interview, you have questions about what's being asked or if you have questions about how the information will be used, please let me know. If you have additional questions after the interview has concluded, please contact Dawn Davidson or Aaliyah Goodie at Nevada Institute for Children's Research and Policy at (702) 895-1040.

Thank you again for your time and participation!

1. Do you provide services in Clark County, Nevada?	
Yes	No (You do not qualify for this interview. Thank you for your time.)

2. Please select the field(s) which best describe your work. (Select all that apply.)				
Housing	Substance use treatment	Harm reduction	Peer support	Recovery services
Prevention		Law enforcement		First responder
Other (please describe):				

3. Which best describes your organization? (Select all that apply.)			
State government		County government	City government
Non-profit direct service provider	For-profit direct service provider	Non-profit other	For-profit other
Other (please describe):			

4. How long have you been with your organization?					
Less than a year	1-2 Years	3-5 Years	6-9 Years	10-15 Years	More than 15 years

5. Please indicate how much you believe each of the following contributes to overdose in our community.				
A. Lack of transportation	To a great extent	Somewhat	Very little	Not at all
B. Lack of housing	To a great extent	Somewhat	Very little	Not at all
C. Lack of funding	To a great extent	Somewhat	Very little	Not at all
D. Lack of data sharing	To a great extent	Somewhat	Very little	Not at all
E. Stigma	To a great extent	Somewhat	Very little	Not at all
F. Unsafe drug supply	To a great extent	Somewhat	Very little	Not at all
G. Poor care coordination between service providers	To a great extent	Somewhat	Very little	Not at all
H. Lack of evidence based primary prevention programs in PreK-12 education	To a great extent	Somewhat	Very little	Not at all
I. Insufficient access to harm reduction services	To a great extent	Somewhat	Very little	Not at all

The following section is designed to gather information about your experience accessing funding to provide services for the community. Please answer the questions based on your experience and to the best of your ability.

6. How is your organization funded? (Select all that apply.)			
Self-supported through grant funding	Government funded	Privately funded	In-kind donations
Other (please describe):			

7. How easy or difficult is it to access funding to support your work?				
Very Easy	Easy	Difficult	Very Difficult	N/A (not self-supported)

8. Please indicate how much you agree or disagree with the following statement: *There are not enough funding opportunities to support work around overdose/harm reduction services in the community.*			
Strongly disagree	Disagree	Agree	Strongly agree

9. Have you applied for funding related to overdose/harm reduction in the past 5 years?		
Yes	No	I'm not sure (Skip to Q10)

If yes,	**For funding you applied for and received in this area in the past 5 years, why do you think you received it/what were your strengths?**
	For funding you applied for and didn't receive in this area in the past 5 years, why do you think you didn't receive it/what were your weakness?
If no,	**What are the reasons why you haven't applied for funding?**

10. What barriers do you encounter in seeking funding to support your work?

The following section is designed to gather information about your experience with data and data sharing. Please answer the questions based on your experience and to the best of your ability.

11. Does your organization collect any data that other organizations might find useful to their work?		
Yes	No	I'm not sure

12. Has your organization shared data with other organizations? If so, how did you share it and what was the intent? (For example, a report distributed to the general public, a presentation at a meeting, specific data that an organization requested for a grant application, etc.)
13. What type of data would you like to see collected or shared with you or your organization and how would you use that data?
14. What would make it easier to accomplish data sharing among organizations?

The following section is designed to gather information about your experiences with stigma when serving the community. Please answer the questions based on your experience and to the best of your ability.

15. Please indicate how often each of the following has occurred.					
A. I have heard other agencies use stigmatizing language when talking <u>about</u> clients/patients.	Often	Sometimes	Rarely	Never	N/A
B. I have heard other agencies use stigmatizing language when talking <u>to</u> clients/patients.	Often	Sometimes	Rarely	Never	N/A
C. I have heard co-workers use stigmatizing language when talking <u>about</u> clients/patients.	Often	Sometimes	Rarely	Never	N/A (I don't work with clients/patients)
D. I have heard co-workers use stigmatizing language when talking <u>to</u> clients/patients.	Often	Sometimes	Rarely	Never	N/A (I don't work with clients/patients)
E. I have talked about a client/patient in ways that I wouldn't if they were present.	Often	Sometimes	Rarely	Never	N/A (I don't work with clients/patients)
F. I have spoken up when I have heard others use stigmatizing language.	Often	Sometimes	Rarely	Never	N/A

What is your age? _____	Prefer not to answer				
What is your gender?	Male	Genderqueer/Gender-nonconforming			Transgender
	Female	Gender not listed (please indicate) _____			Prefer not to answer
Please circle all that apply to you.	American Indian or Alaska Native	Asian		Black/African American	Hispanic/Latinx
	Native Hawaiian/ Pacific Islander	White/Caucasian		Other	Prefer not to answer
What is your educational level?	Less than high school	High School Diploma/GED	Some College	Bachelor's Degree (e.g. BA or BS)	Graduate Degree	Prefer not to answer

Appendix C: Agency Affiliation of those Participating in the Community Partner Interview

- Crossroads of Southern Nevada
- EMPOWERED at Roseman University College of Medicine
- Foundation for Recovery (FFR)
- Hello Hales LLC
- PACT Coalition
- Statewide Substance Use Response Working Group
- The LGBTQIA+ Community Center of Southern Nevada
- There is No Hero in Heroin (TiNHiH)
- Trac-B/Impact Exchange

Appendix 4: Clark County Center for Substance Recovery Proposal

(Starts on the next page)

Clark County Center for Substance Recovery

togetherforbetter

Introduction

A. National Overview of the Opioid Crisis

- The opioid crisis in the United States has been escalating over the years, characterized by a significant increase in the use, misuse, and overdose deaths associated with opioid medications, including prescription pain relievers, heroin, and synthetic opioids such as fentanyl.
- Currently in "4th wave" of the crisis
  - 1st wave began with increased prescribing of opioids in the 1990s
  - 2nd wave began in 2010 with heroin
  - 3rd wave began in 2013 with the development of synthetic opioids (i.e. fentanyl)
  - 4th wave is characterized by deaths involving fentanyl plus a stimulant (i.e. cocaine or methamphetamine)
    - Most of the street drug supply is now adulterated with opioids such as fentanyl
- In **2021, it was estimated that more than 107,000 people died of drug overdose in the US**, marking the highest ever recorded annual number of overdose deaths in the nation.
- According to the Centers for Disease Control and Prevention (CDC), **nearly 70% of the drug overdose deaths in 2019 involved an opioid**. This crisis has not only devastated many lives and families but also placed a heavy burden on healthcare systems and the economy.

B. Impact on Urban Areas

- **Urban areas have been particularly hard hit by the opioid epidemic**. Cities offer greater accessibility to both legal and illicit drugs, higher population densities that facilitate the spread of substance use, and often have strained public health resources.
- In urban settings, opioids have contributed to higher rates of nonfatal overdoses and overdose deaths, increased transmission of infectious diseases like HIV and hepatitis C due to needle sharing, and greater economic burdens on local governments.

C. Focus on Clark County

- A recent Nevada need assessment performed by DHHS found that 788 overdose deaths occurred in 2020, an increase of 55% compared to 2019, numbers which are often underreported.
  - In **2023, Clark County (SNHD) reported 237 drug overdose deaths involving fentanyl**, which is **50x more potent that heroin and 100x stronger than morphine.**
- Most overdose deaths involved opioids; however, stimulant use and stimulant-involved overdoses have also increased significantly in recent years.
- Assessment data show that certain racial and ethnic communities, geographic locations, and other groups have been disproportionately impacted by opioid-related harms.
  - **Overdose rates among youth have risen 550%** between 2019 and 2020.

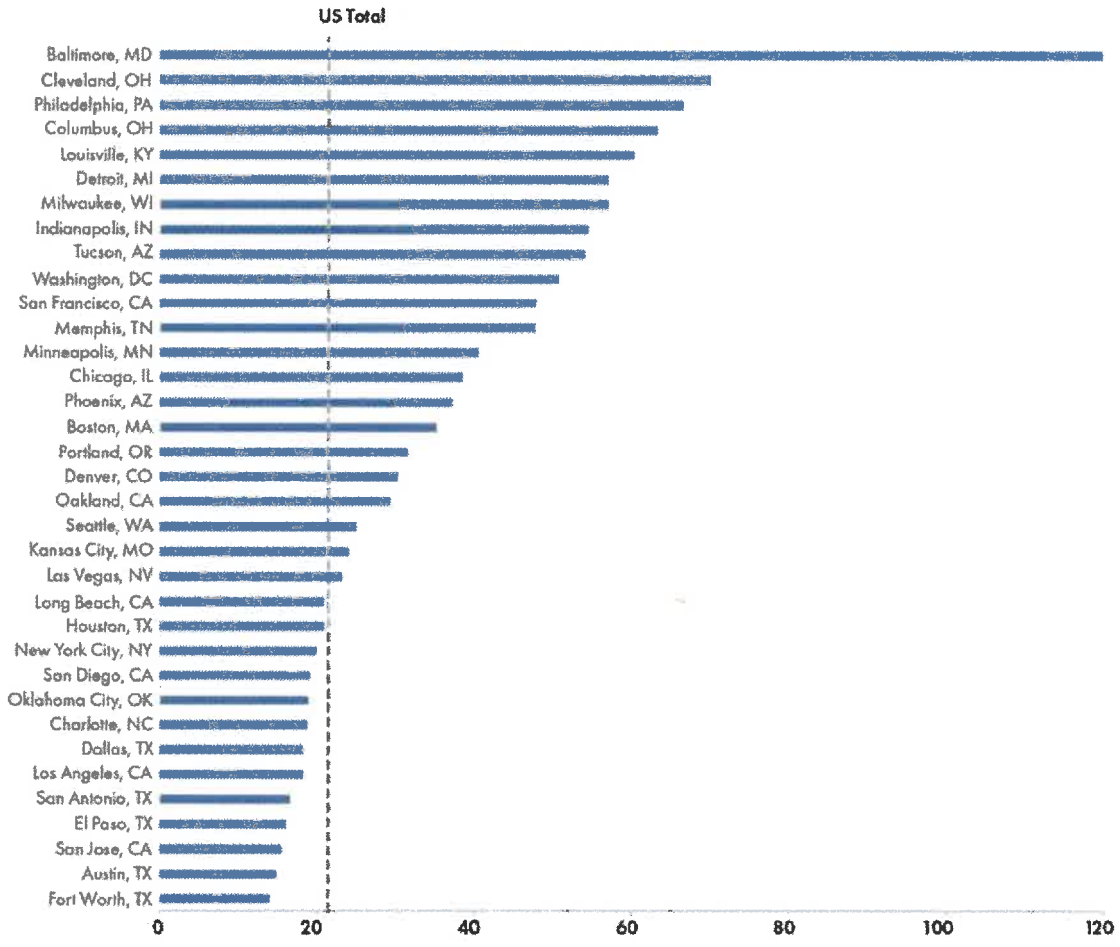
D. Local Statistics and Trends

- According to Mental Health America, **Nevada ranked #51 overall in 2021 and 2022 in regards to prevalence of mental illness and access to care**. This statistic underscores the acute impact of the crisis on this urban area.
- Efforts to address the epidemic in Clark County include increasing access to naloxone, a drug that can reverse opioid overdoses, the promotion of drug take-back programs to reduce the availability of prescription opioids, and distribution of test strips which can be used to determine if drugs have been mixed or contaminated with fentanyl.

E. Conclusion

- Nevada has built a strong foundation of evidence-based treatment, services, and supports across its current system of care, including prevention, treatment, and recovery supports. However, **the current system is fragmented and underdeveloped** and opportunities for strengthening it also exist across all components of care.

Drug OD death rate, 2020 (per 100,000 population, age-adjusted)



Las Vegas ranks #22 in the nation in overdose death rate

Local Statistics

A. Overview of Opioid Overdose Rates
- Clark County has been significantly impacted by opioid overdoses, a trend consistent with the broader crisis affecting Nevada and the United States. Las Vegas, being a major urban center with a large transient population and visitors who come for the 24-hour nature of the city **take what they think is methamphetamine or cocaine, but it is adulterated with fentanyl**.

B. Statistical Trends in Overdose Deaths
- **In 2023, there were 388 total deaths from all opioids in Clark County.**
- From 2018-2023, **Clark County saw a 82% increase in age adjusted overdose death rate involving any opioid**.
  - **Death rate involving fentanyl increased 545% in same time period.**
  - **Death rate involving Rx opioids decreased 37% in the same time period.**
- In addition, **Nevada ranked #51 overall, #51 in youth, #46 in prevalence, and #39 for access** in a recent Mental Health America study on mental health needs across the US states.

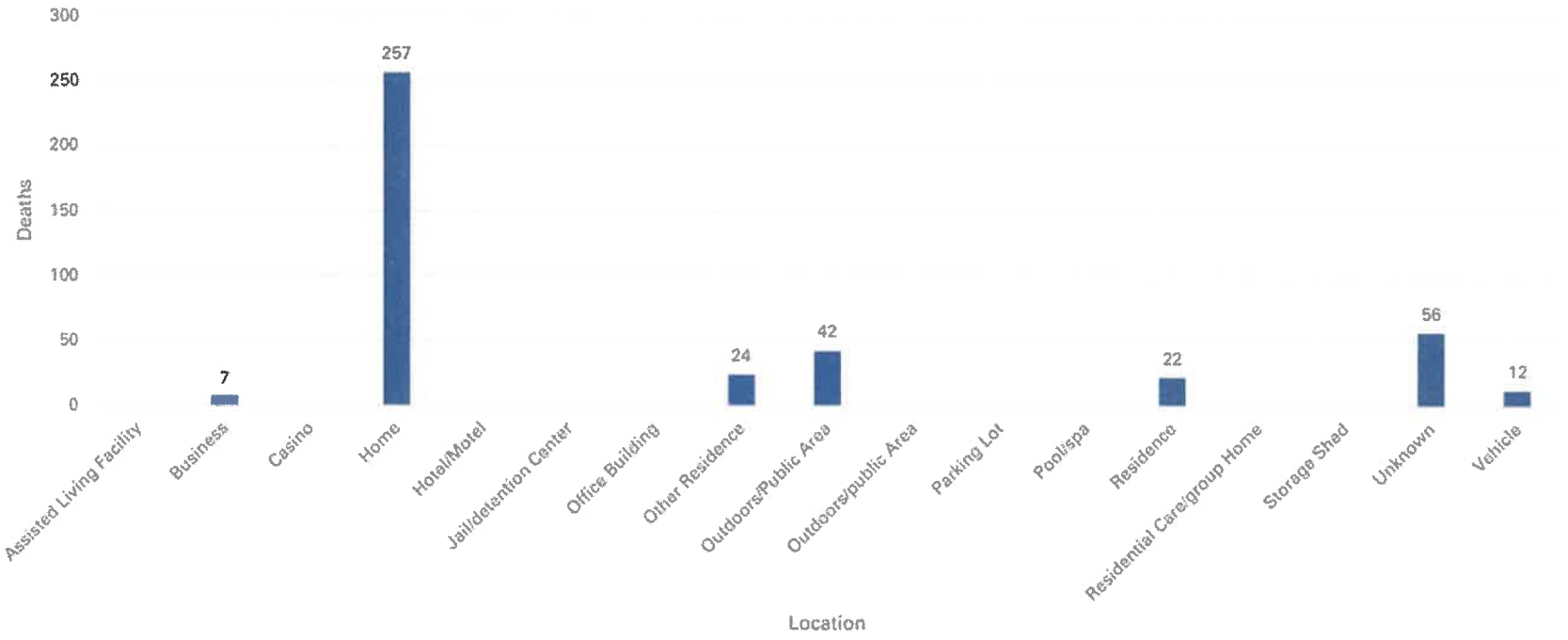
C. The Role of Fentanyl
- In 2023, **78% of the opioid-involved overdose deaths involved fentanyl**.
- Deaths from synthetic opioids increased from **less than 50 in 2010 to nearly 400 in 2023**.

OPIOID DEATHS BY DRUG TYPE

Drug Overdose Death Crosstabulation by Substance Among Clark County Residents, 2023							
	All Opioid	Fentanyl	Heroin	Rx Opioids	Meth	Cocaine	Benzos
All Opioid	388	302	39	81	155	48	64
Fentanyl		302	13	31	135	44	37
Heroin			39	5	18	-	-
Rx Opioids				81	15	6	28
Meth					290	25	13
Cocaine						75	5
Benzos							74

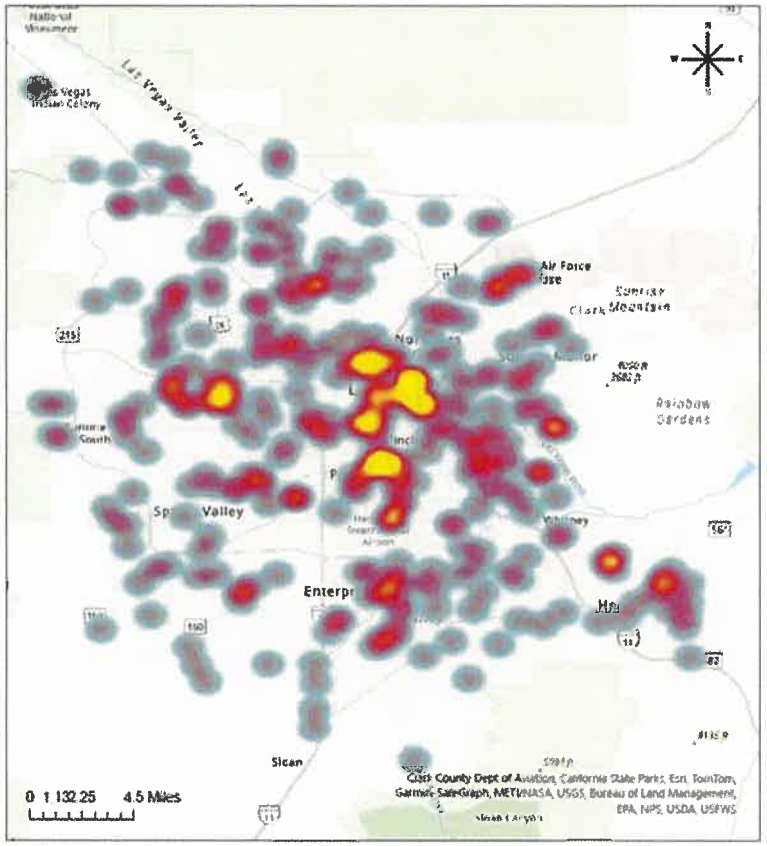
Note: Count data less than 5 are suppressed to protect confidentiality and to safeguard protected health information.

OPIOID DEATHS BY LOCATION



FATAL OPIOID OVERDOSE HEAT MAP (2023)

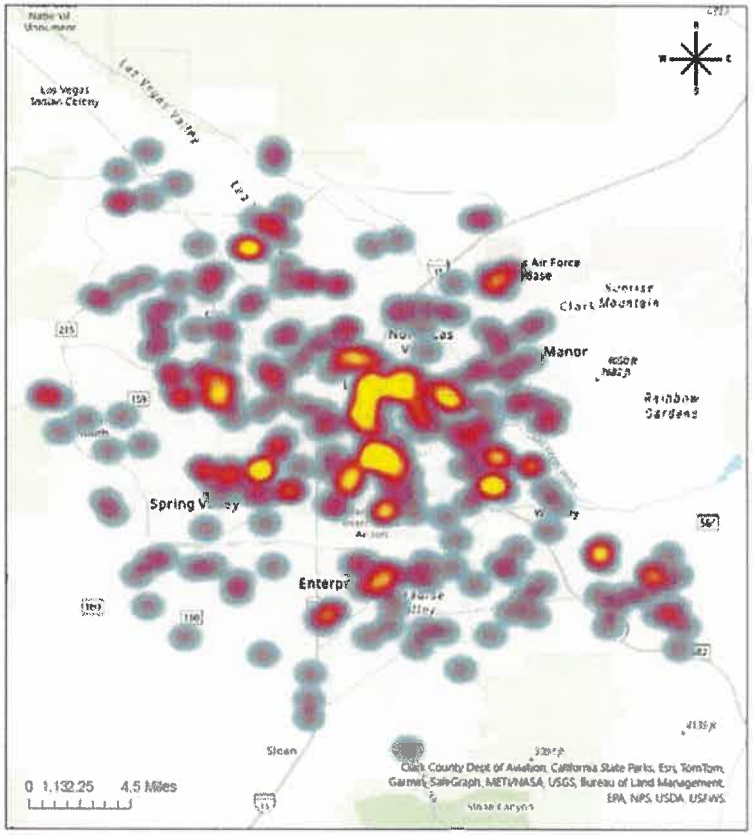
Residence



Sparse
Dense

Clusters are located Downtown, Washington & H St, and UNLV (Flamingo & Paradise).

Injury Location

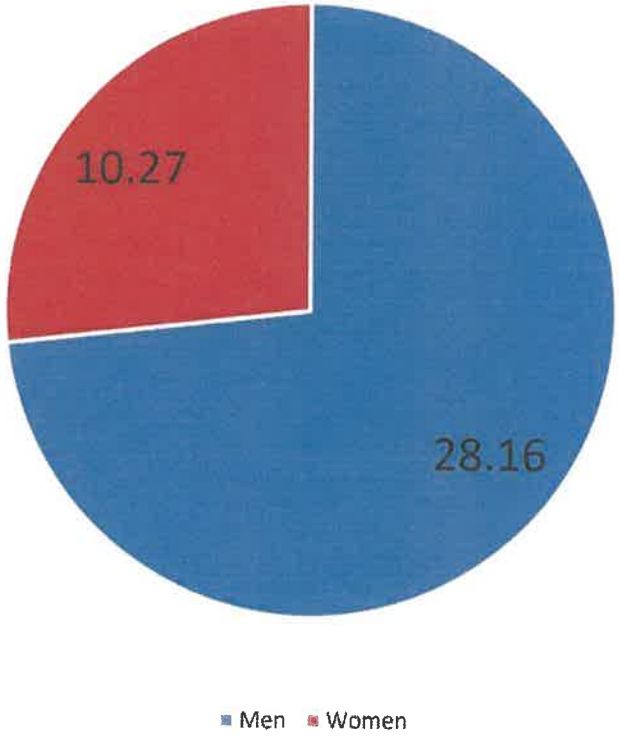


Sparse
Dense

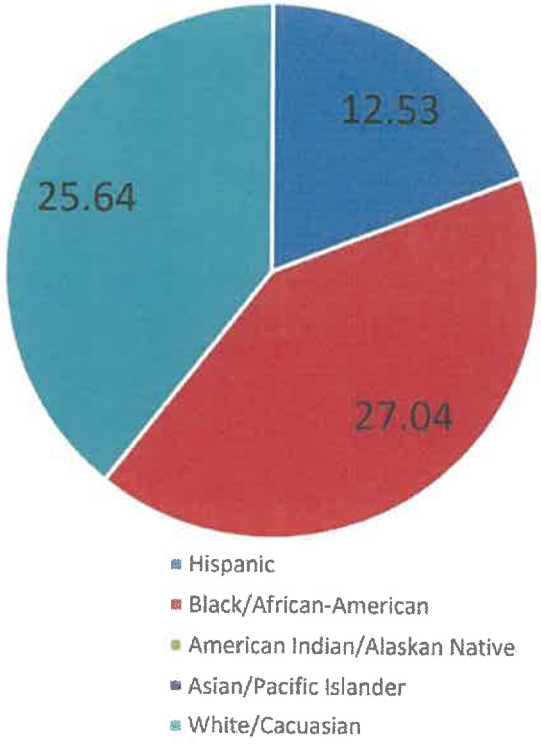
Clusters are located Downtown, 13th & Stewart, Naked City/Arts District, and UNLV.

OPIOID OVERDOSE DEATH DESCRIPTIVE STATS (2023)

Crude Opioid Overdose Death Rate by Gender per 100,000 Clark County Residents, 2023



Crude Opioid Overdose Death Rate by Race/Ethnicity per 100,000 Clark County Residents, 2023



D. Impact on Local Health Resources

- The rising number of opioid overdoses has placed a significant burden on local healthcare systems, including emergency services, hospitals, and long-term rehabilitation centers. The demand for medical and psychological support for addiction and overdose has strained these resources, highlighting the need for increased funding and expanded services.
- From **2019 -2023, there were approximately 2,000 cases opioid related cases which went to local acute care hospitals** which could have been redirected to a substance abuse center and generated approximately **$30M in direct revenue**.
  - From 2019-2020, opioid related **hospital emergency room admissions increased 23%.**

E. Government and Community Response

- Local government and community organizations have been actively involved in trying to mitigate the impact of opioid misuse.
  - **Clark County Regional Opioid Task Force**
  - **Substance Use Response Working Group (SURG, NVAG)**
  - **Advisory Committee on a Resilient Nevada (ACRN)**
  - **Fund for a Resilient Nevada (FRN)**
  - **Southern Nevada Opioid Advisory Council (SNOAC)**
  - **Southern Nevada Harm Reduction Alliance**
  - **Opioid Needs Assessment and State Plan**

F. Conclusion

- The statistics from Clark County reflect both the challenges and the critical need for targeted interventions to address the opioid crisis. Continued monitoring and responsive public health strategies are essential to combat the **rising tide of opioid misuse and overdose deaths in the area**.
- These statistics provide a clear picture of the severity of the opioid crisis in Clark County, underscoring the **importance of concerted efforts to address the issue through comprehensive public health and community-based interventions**.
- Although there are many efforts, groups, organizations, and committees formed to address the opioid crisis, **there does not appear to be a central point of clinical delivery and assistance to mitigate this epidemic**.

Challenges Faced by the Community

A. Local Conditions and Challenges

- Las Vegas' unique demographic and economic factors contribute to its specific challenges regarding opioid misuse. As a major tourist destination known for its nightlife and entertainment, the city attracts a diverse range of individuals, including transient populations who may be more vulnerable to substance use disorders.
- The city's healthcare infrastructure, while extensive, is often stretched thin by the high demand for emergency and addiction services, exacerbated by the high rates of substance abuse among both residents and visitors.

B. Opioid Use Trends in Clark County

- Fentanyl has emerged as a particular concern in Las Vegas, mirroring national trends but with notable local implications. The synthetic opioid is extremely potent and has been responsible for a significant increase in overdose deaths in the area. Many users are often unaware of fentanyl's presence in the drugs they consume, leading to accidental overdoses.
- Overdose death rates in Las Vegas have been on the rise, with opioids playing a major role in these fatalities. The increase in opioid-related deaths has been significant enough to prompt heightened responses from public health and safety officials.

C. Public Health Response

- In response to the crisis, Clark County has implemented several public health initiatives aimed at curbing opioid misuse and its consequences. These include widespread distribution of naloxone, a life-saving medication that reverses opioid overdoses, and public education campaigns on the dangers of opioid use.
- The establishment of the Clark County Regional Opioid Task Force is a pivotal step in coordinating efforts across different sectors to effectively address the crisis. This task force works on enhancing prevention, treatment, recovery, and response strategies to reduce opioid misuse and deaths.

D. Community and Advocacy Efforts

- Local nonprofits and advocacy groups play a critical role in addressing the opioid crisis in Las Vegas. These organizations often spearhead community outreach programs, support groups, and educational initiatives to raise awareness about opioid addiction and promote healthier choices.
- Efforts such as annual walks, community forums, and partnership with local businesses and government entities are essential in mobilizing community action against the opioid epidemic.

E. Future Directions

- Moving forward, Clark County faces the challenge of **integrating more comprehensive treatment options, such as medication-assisted treatment (MAT) programs**, into its healthcare system. These programs are crucial in providing long-term support for individuals recovering from opioid addiction.
  - **MAT is an approach that combines the use of medications with counseling and behavioral therapies**.
  - Common medications used in MAT include **methadone, buprenorphine, and naltrexone** which all manage withdrawal symptoms and reduce the risk of relapse.
- Continued collaboration between local government, healthcare providers, community organizations, and law enforcement will be essential to develop and implement strategies that effectively address both the immediate and underlying issues related to opioid misuse.
- The response to the opioid crisis is multifaceted, addressing both the immediate needs for overdose prevention and long-term strategies for reducing dependency. The county's public health officials, community leaders, and healthcare providers continue to work together to tackle the complexities of the opioid epidemic, aiming to reduce its impact on the community and improve public health outcomes.

Current Resources and Gaps

A. Current Resources
   - Naloxone Distribution: Clark County has seen increased distribution of naloxone, a drug that can reverse opioid overdoses, available through pharmacies, community programs, and emergency responders.
   - Treatment Facilities: There are opioid treatment programs that offer a range of services including detoxification, medication-assisted treatment (MAT), and counseling. These facilities range in scope from inpatient mental health hospitals with the ability to treat acute intoxication to various rehabilitation centers which do a combination of detox, inpatient, and outpatient services.
   - Public Education and Prevention Programs: Efforts to educate the public on the dangers of opioid misuse and the availability of treatment options are ongoing. These programs are crucial for prevention and are often carried out in schools, workplaces, and community centers.

B. Gaps in Services
   - Accessibility and Capacity: Despite the availability of treatment facilities, there are significant gaps in accessibility for many residents, particularly those without insurance or those living in underserved areas. The capacity of existing facilities often cannot meet the high demand for services.
   - Integrated and Comprehensive Care: There is a need for more integrated care systems that not only focus on treating addiction but also address the underlying social and mental health issues associated with substance use disorders. This includes housing, employment support, and mental health services.
   - Recovery and Aftercare Services: There is a lack of long-term recovery and aftercare services, which are critical for maintaining sobriety and preventing relapse. Services such as sober living homes, ongoing counseling, and employment training are needed to support individuals in their recovery journey.

- Public Awareness and Stigma: While there are efforts to educate the public, stigma surrounding opioid addiction still persists, which can deter individuals from seeking help. Increased awareness campaigns that focus on addiction as a medical condition could help reduce stigma and encourage more people to access treatment.

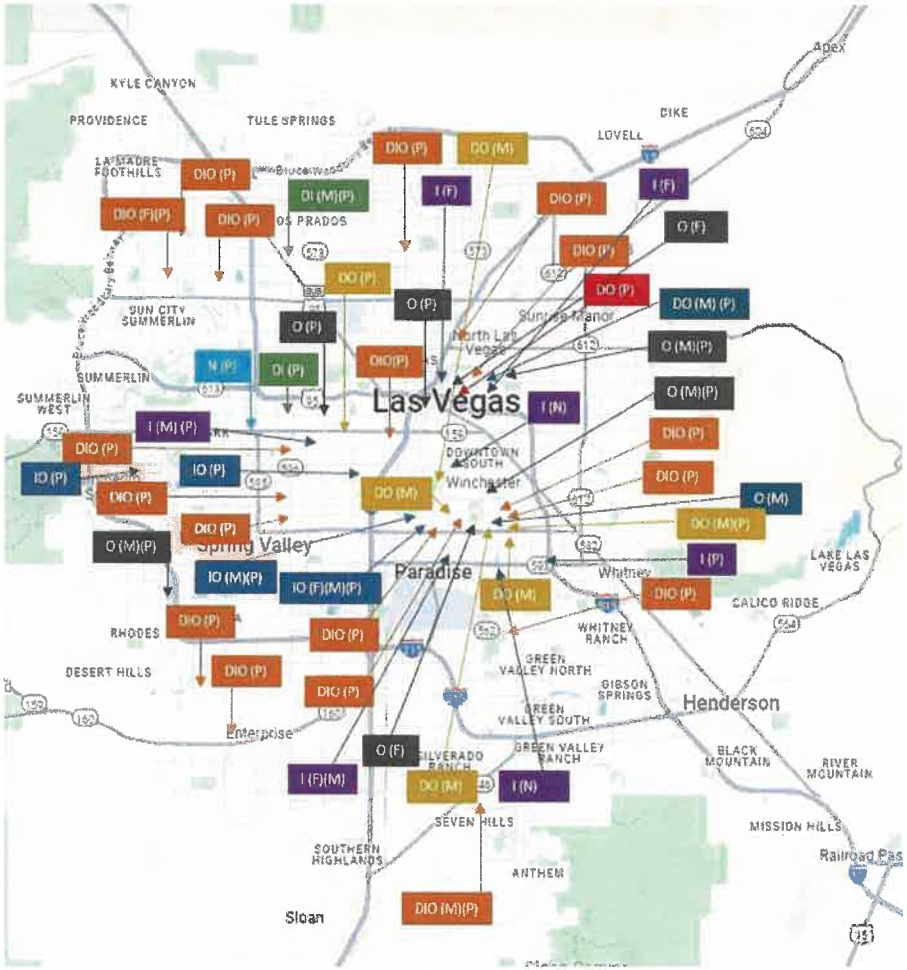
C. Recommendations for Addressing Gaps

- Increase Funding for Treatment Programs: Additional funding is necessary to expand the capacity of existing treatment facilities and to establish new ones, particularly in high need areas
- Enhance Integrated Services: Develop more comprehensive treatment programs that integrate physical health, mental health, and social services to address all aspects of a person's well-being.
- Expand Recovery and Support Networks: Increase investment in recovery support services, such as peer support groups, sober living arrangements, and community-based aftercare programs.
- Improve Outreach and Education Efforts: Launch more targeted education programs that reach out to various demographics, including young adults, older populations, and minority communities, to better educate them on the risks of opioids and the resources available for help.

D. Stakeholder Involvement

- Collaboration among healthcare providers, policy makers, community leaders, and affected families is crucial for developing effective strategies to fill these gaps. Engaging all stakeholders in a concerted effort can lead to more effective solutions and broader community support for individuals affected by the opioid crisis.
- Addressing these gaps requires a coordinated effort that not only expands existing resources but also adapts services to meet the specific needs of the Las Vegas community. Through comprehensive strategies and sustained support, it is possible to make significant progress in combating the opioid epidemic in the region.

BEHAVIORAL HEALTH CENTERS – CLARK COUNTY



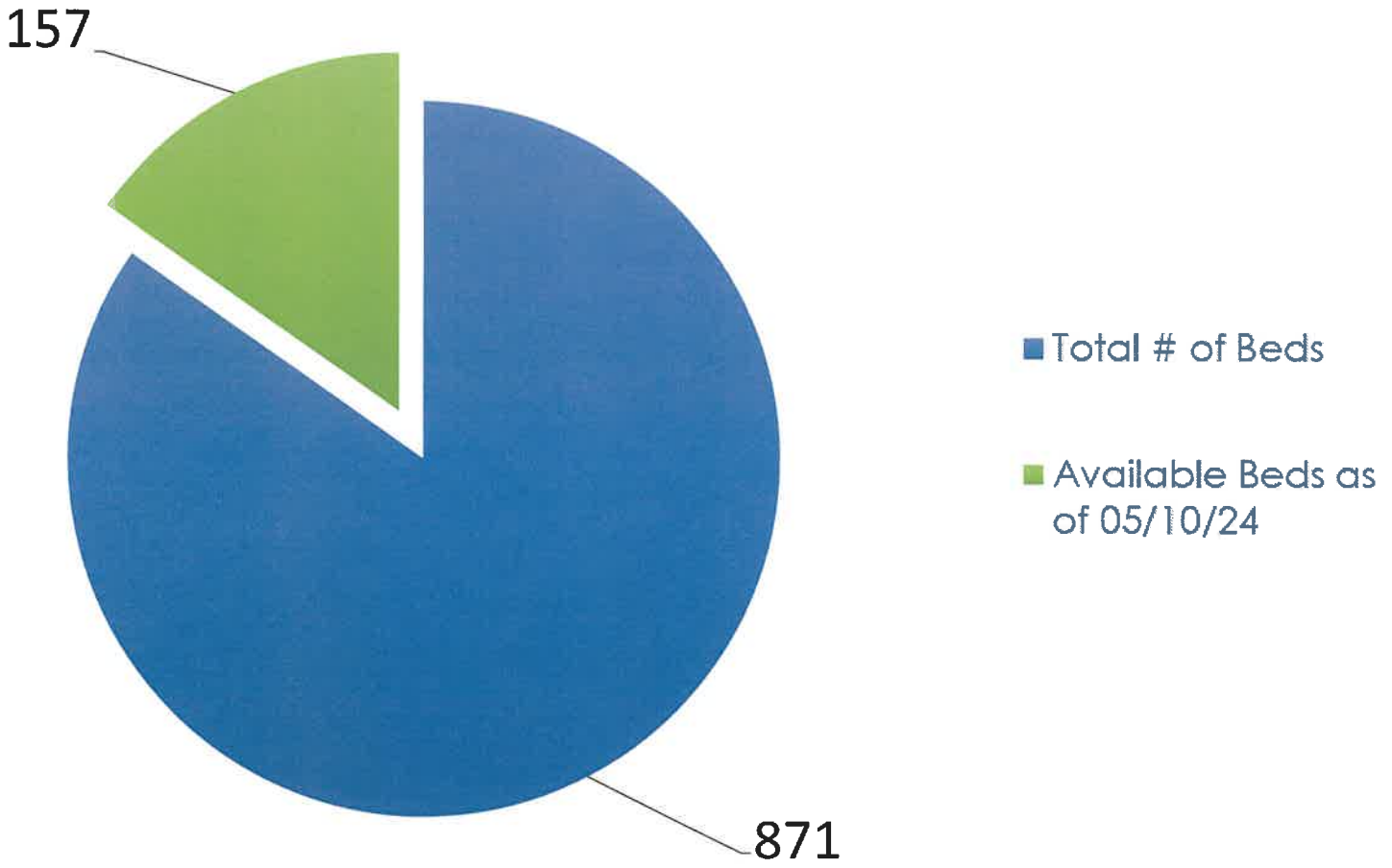
LEGEND:

- **DIO** - Detox Inpatient Outpatient
- **DO** – Detox Outpatient
- **DI** – Detox Inpatient
- **IO** – Inpatient Outpatient
- **I** – Inpatient
- **O** – Outpatient
- **N** – N/A

(P) – Private
(M) – Medicaid
(F) – Free
(N) – N/A

- Approximately 60 drug rehabilitation centers in Clark County offering varying services (detox, inpatient, outpatient) for varying payors (private, Medicaid, free).
- Only 9 SAMHSA approved opioid treatment centers in Clark County.

ACUTE CARE INPATIENT BEHAVIORAL BEDS



Benefits of Establishing a New Treatment Center

A. Enhanced Access to Specialized Care
- Increased Treatment Capacity: A new treatment center would expand the availability of opioid addiction services, including detoxification, medication-assisted treatment (MAT), and counseling. This is crucial in a city where current facilities may be at capacity and unable to meet the growing demand.
- Specialized Programs: With the establishment of a new center, there is an opportunity to offer specialized programs tailored to diverse populations, such as adolescents, veterans, or people with co-occurring mental health disorders.

B. Reduction in Overdose Deaths
- Immediate Intervention: Increased access to treatment can lead directly to a reduction in overdose deaths. Treatment centers provide necessary interventions like naloxone distribution and emergency care that can save lives in acute situations.
- Long-term Health Improvements: Ongoing treatment and support services help individuals achieve and maintain sobriety, significantly reducing the risk of fatal and non-fatal overdoses.

C. Economic Benefits
- Reduced Healthcare Costs: Effective treatment reduces the need for emergency medical services and hospitalizations related to overdoses, thereby decreasing overall healthcare costs.
- Increased Productivity: Recovering individuals can contribute more effectively to the economy through stable employment and increased productivity, benefiting the community economically.

D. Social and Community Impact
   - Improved Public Safety: Treatment centers help reduce drug-related crime and improve public safety by addressing the root causes of addiction. This can lead to a more stable and safe community environment.
   - Community Engagement and Support: Establishing a new center can strengthen community ties and promote a supportive environment that is critical for recovery. This includes creating opportunities for community-based recovery programs and partnerships with local businesses and educational institutions.

E. Education and Prevention
   - Awareness and Stigma Reduction: A treatment center also serves as a hub for education and awareness campaigns that can help reduce the stigma associated with addiction. By promoting understanding and support, the center can encourage more individuals to seek help early.
   - Preventive Education: The center can provide preventive education to at-risk populations, including youth and young adults, which is essential for reducing the initiation into opioid use.

F. Research and Development
   - Innovations in Treatment: A new center can also be a site for research and development of new treatment methods and interventions. Collaboration with academic institutions and participation in clinical trials can lead to innovations that improve treatment outcomes not only locally but on a broader scale.

G. Broaden Support Networks

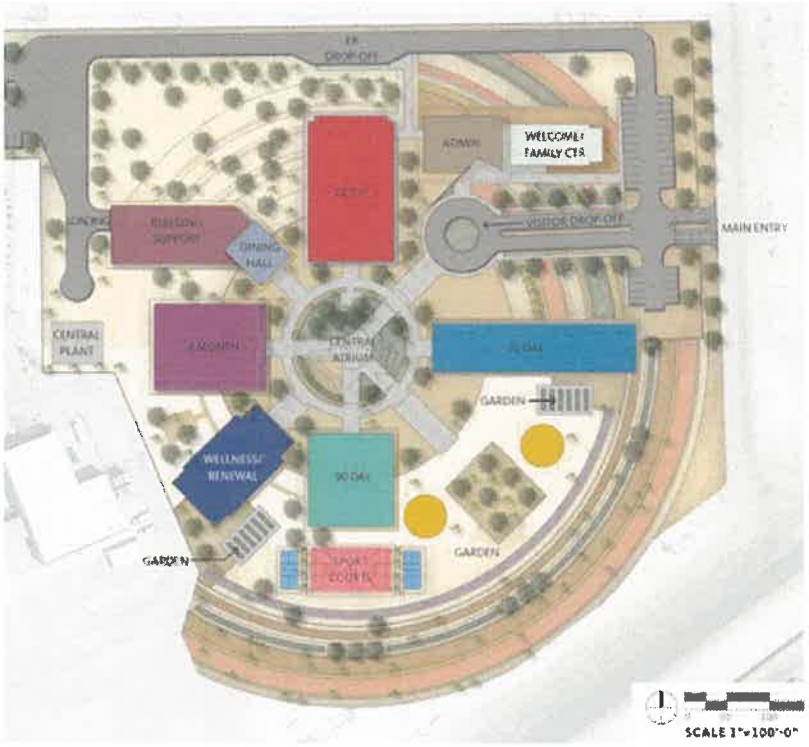
- Integration of Services: By integrating various services, such as mental health care, social services, and legal aid, into the treatment process, a new center can provide a holistic approach to recovery, which is more effective in the long term.

H. Conclusion

- The establishment of a new opioid treatment center in Las Vegas would bring multifaceted benefits, addressing both immediate and long-term needs of individuals struggling with opioid addiction. This initiative would not only enhance the health and safety of the community but also contribute positively to its economic and social fabric.

Proposed Features of the Treatment Center

Current Proposed Site Plans



Residential Program: 240 Beds Total:

- Detox (48 Beds Total).
- 30-Day Stay (96 Beds Total). (recommend more)
- 90-Day Stay (64 Beds Total).
- 6-Month Stay (32 Beds Total).

Support Program:

- Administration.
- Welcome & Family Center.
- Wellness/Renewal Center.
- Building Support.
- Outdoor Amenities.

SCOPE OF PROGRAM

A. Opioids
   - Including prescription painkillers (like oxycodone and hydrocodone, illegal drugs (like heroin), and synthetic drugs (like fentanyl). Treatments often use medication-assisted therapies (MAT) such as methadone, buprenorphine, or naltrexone. Detoxification is sometimes needed for patients in acute overdose episodes.

B. Alcohol
   - Treatment typically involves detox, behavioral therapies, and support groups.

C. Benzodiazepines
   - Treatment for addiction to sedatives like Valium and Xanax usually includes tapering the drug's use under medical supervision to manage withdrawal symptoms safely

D. Stimulants
   - Such as cocaine and methamphetamines. Treatment may include behavioral therapies and support groups since there are currently no FDA-approved medications for treating addiction to these substances

SCOPE OF PROGRAM

E. Nicotine
- Often treated with a combination of medication and behavioral therapies

F. Club Drugs
- Including MDMA (ecstasy), GBH, and others. Treatment focuses on psychotherapy and support groups.

G. Hallucinogens
- Like LSD and psilocybin, which generally require psychotherapeutic approaches to treatment.

The specific treatment strategies can vary depending on the substance involved and the individual's needs, often involving a combination of detoxification, medication, therapy, and support mechanisms to aid recovery and prevent relapse.

BED COMPLMENT BENEFITS

30-Day Programs: These programs are typically introductory and focus on detoxification along with beginning the journey of rehabilitation. They can serve as a good starting point for many individuals, providing structured therapy and helping patients develop a continuation or aftercare plan. However, they may be less effective for severe addictions or those long-standing behavioral issues as they provide a limited time to address complex issues.

90-Day Programs: Research indicates that longer duration treatments, such as 90-day programs, are significantly more effective in maintaining sobriety. These programs allow more time for detoxification, therapy, and skills development crucial for relapse prevention. They offer comprehensive support, including behavioral therapies like cognitive-behavioral therapy (CBT) and contingency management, and often involve family in the recovery process. Studies show that extended stays in such programs are associated with better outcomes, including reduced relapse rates and improved overall functioning.

6-Month Programs: Extended programs that last for about six months provide an even deeper level of care. These programs are particularly beneficial for those with chronic addiction issues, offering ongoing support and more time to practice recovery skills in a safe environment. The long duration helps solidify habits of sober living and thoroughly addresses the psychological aspects of addiction. Facilities that provide such long-term care often see improved results in terms of patient recovery stability and lower relapse rates.

BED COMPLEMENT RECOMMENDATIONS

Detox Beds: It's common for patients to require detox beds before transitioning to further treatment. Typical duration of stay for detox is usually 5 to 10 days. Detox areas do not require as long as a stay as rehabilitation programs but do need to be readily available for new patients.

30-Day Programs: Short-term programs are typically entry points for many seeking initial treatment and can have higher turnover rates. Allocating a larger number of beds to this program can accommodate the higher admission rates typically associated with shorter stays.

90-Day Programs: Given the evidence supporting longer treatment durations for improved outcomes, a significant portion of the facility should be dedicated to these programs. They provide a balance between intensive care and manageable stay duration, making them appealing to many patients and their families.

6-Month Programs: These programs are crucial for individuals with more severe addiction issues or those who have not succeeded in shorter programs. While the demand may be lower than for shorter programs, the impact and complexity of care provided justify dedicating a substantial portion of the center's resources.

BED COMPLEMENT RECOMMENDATIONS

Suggested Allocation:

• Detox Beds: **15%** of total beds	(36 beds)	↓ 48
• 30-Day Programs: **35%** of total beds	(84 beds)	↓ 96
• 90-Day Programs: **35%** of total beds	(84 beds)	↑ 64
• 6-Month Programs: **15%** of total beds	(36 beds)	↑ 32
Total Beds	240 beds	

PROGRAMS AND SERVICES

A. Comprehensive Treatment Services
- Detoxification Services: Offering medically supervised detox to help patients safely withdraw from opioids, which is the first step in the recovery process
- Medication-Assisted Treatment (MAT): Providing FDA-approved medications such as methadone, buprenorphine, and naltrexone to help reduce cravings and withdrawal symptoms
- Counseling and Behavioral Therapies: Incorporating individual counseling, group therapy, and family therapy sessions to address psychological aspects of addiction.
- Inpatient services (30, 90, 180 day treatment) and Outpatient services (intensive and traditional)

B. Integrated Care Programs
- Co-occurring Disorders Treatment: Programs designed to treat not only substance abuse but also accompanying mental health conditions such as depression, anxiety, or PTSD.
- Physical Health Services: Including general healthcare services to address physical health issues often neglected in those suffering from addiction.

C. Support and Recovery Services
- Aftercare and Relapse Prevention: Establishing strong aftercare programs to support patients after they leave treatment, including ongoing counseling and support groups.
- Sober Living Arrangements: Offering or coordinating with sober living homes to provide a drug-free environment that supports recovery.

PROGRAMS AND SERVICES

D. Educational and Outreach Programs
- Community Education Initiatives: Conducting workshops and seminars in schools, workplaces, and community centers to educate the public about the risks of opioid use and the benefits of treatment.
- Programs for Pregnant Women: Specialized care for pregnant women dealing with opioid addiction, ensuring the safety and health of both mother and child.

E. Specialized Programs
- Youth and Adolescent Programs: Tailored programs for younger individuals who require different approaches in treatment and counseling.
- Programs for Pregnant Women: Specialized care for pregnant women dealing with opioid addiction, ensuring the safety and health of both mother and child.

F. Technology Integration
- Telemedicine Services: Utilizing telemedicine to provide continuous care and support, especially for patients who may not be able to consistently travel to the treatment center.
- Mobile Apps for Support and Management: Development of mobile applications that can provide support tools, reminders for medication, and direct links to counselors or emergency help.

PROGRAMS AND SERVICES

G. Legal and Social Service Coordination

- Legal Aid Services: Offering access to legal aid to help patients navigate issues like custody disputes, criminal charges, or employment discrimination related to their addiction history.
- Employment and Educational Assistance: Programs to help recovering individuals reintegrate into the workforce or continue their education.

H. Conclusion

- These proposed features aim to create a comprehensive and integrated approach to opioid addiction treatment in Las Vegas, addressing not only the medical and psychological aspects of recovery but also the social, legal, and economic challenges that patients often face. This holistic approach is crucial for the long-term success of individuals in recovery and for the health of the community as a whole.

OUTPATIENT PROGRAMS

A. Intensive Outpatient Therapy (IOP)
- **Intensity and Time Commitment:** IOPs require a significant commitment, generally involving multiple sessions per week, each lasting several hours. Commonly, this might include 9 to 20 hours per week of therapy.
- **Services Offered:** These programs offer a rigorous treatment schedule designed to address complex addiction issues without requiring overnight stays. Treatments often include group therapy, individual counseling, and educational sessions about substance abuse, relapse prevention, and sometimes family counseling.
- **Suitable For:** IOPs are intended for individuals who need more support than what typical outpatient therapy offers but who also have a stable home environment. It's suitable for those transitioning from residential treatment of those whose condition requires a structured therapy regimen but allows them to remain in their community and possibly continue working or attending school.

B. Outpatient Therapy (OP)
- **Intensity and Time Commitment:** This form of therapy typically involves less than IOP, often ranging from 1 to 8 hours per week, based on individual needs.

OUTPATIENT PROGRAMS

- **Services Offered:** Standard outpatient programs usually involve weekly or biweekly meetings with a therapist or counselor for individual sessions, group therapy, or both. The focus is often on counseling and less intensive than IOP
- **Suitable For:** OP is best suited for individuals who need a flexible schedule to manage their recovery while maintaining their regular responsibilities like work, school, or family. It's often recommended for those with a mild form of addiction or those well into their recovery needing continued support.

C. Key Differences

- **Frequency and Duration of Sessions:** IOPs are more intense, requiring more hours per week, whereas Ops require fewer weekly hours and are less intense.
- **Level of Care:** IOPs provide a higher level of care than standard outpatient programs, suitable for those needing more structured support without inpatient care.
- **Lifestyle Integration:** Both programs allow patients to live at home, but IOPs might restrict some aspects of personal life due to the intensity of the program

Choosing between IOPs and OP usually depends on the individual's specific needs, their level of addiction, personal responsibilities, and their support system at home.

Case Studies of Successful Treatment Centers

A. The Hazelden Betty Ford Foundation
- Location: Multiple locations across the U.S.
- Approach: Integrates medical, mental, and holistic health services with peer-led community-based recovery support.
- Innovations: Hazelden pioneered the use of the "Minnesota Model," a whole-person approach to addiction treatment, which has since been adopted worldwide. They also focus heavily on family involvement and support systems, recognizing the importance of this network in the recovery process.
- Outcomes: High success rates in patient recovery and long-term sobriety, supported by robust follow-up care and alumni networks.

B. Behavioral Health of Palms Beach
- Location: Florida
- Approach: Known for its research-based, comprehensive treatment programs that address both substance abuse and co-occurring mental health disorders.
- Innovations: Offers a variety of specialized treatment programs, including ones for first responders, healthcare professionals, and those dealing with trauma. Utilizes evidence based therapies like cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and motivational interviewing.
- Outcomes: Demonstrates a strong track record in reducing relapse rates and improving overall mental health outcomes.

C. Phoenix House

- Location: Multiple locations across the U.S.
- Approach: Provides a continuum of care from detox and residential treatment to outpatient services and sober living.
- Innovations: Emphasizes the role of personal responsibility and the development of a solid support network, which is facilitated through various community-centric programs and activities.
- Outcomes: Success in long-term recovery, evidenced by extensive follow-up with clients and a focus on sustainable living practices post-treatment.

D. McLean Hospital

- Location: Massachusetts
- Approach: As part of the Harvard Medical School, McLean provides cutting-edge treatment informed by the latest research in neuroscience and psychiatry.
- Innovations: Specializes in treating substance use disorders alongside mental health conditions, using advanced medical and psychotherapeutic methods. Also focuses heavily on research and development to continually evolve its treatment protocols.
- Outcomes: Noted for its high rates of patient satisfaction and effectiveness in treating complex psychiatric and substance use disorders.

E. Caron Treatment Centers
   - Location: Pennsylvania
   - Approach: Caron uses a comprehensive and personalized approach to treatment, which includes medical care, psychotherapy, and spiritual and emotional support.
   - Innovations: Offers age-specific programs and has specialized tracks for different demographics, including teens, young adults, and older adults, recognizing the unique challenges faced by these groups.
   - Outcomes: Known for its strong emphasis on family involvement and extensive aftercare planning, which has led to high success rates in maintaining long-term sobriety.

F. Conclusion
   - Each of these centers demonstrates a commitment to comprehensive care, ongoing innovation in treatment practices, and the importance of tailored programs to meet the needs of diverse populations. By examining their approaches, successes, and areas of specialty, stakeholders in Las Vegas could gain valuable insights into potential features and strategies to implement in a new local opioid treatment center.

Funding and Support

A. Federals Grants
   - Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA offers several grant programs that can support opioid addiction treatment programs, including grants specifically aimed at medication-assisted treatment (MAT) and the expansion of treatment services in underserved areas.
   - Health Resources and Services Administration (HRSA): HRSA provides funding to health centers to help them tackle substance use disorders, including opioid abuse, by expanding access to services.

B. State and Local Government Funding
   - Opioid settlement funding (State, County, Municipality)
   - State Opioid Response Grants: Many states receive federal funding through SAMHSA's State Opioid Response program, which they can allocate to local treatment centers to enhance opioid addiction services.
   - Local Health Departments (SNHD): Local government budgets sometimes include allocations for public health initiatives, including funding for addiction treatment and prevention programs.

C. Private Foundations and Donations
   - Philanthropic Foundations: Foundations such as the Robert Wood Johnson Foundation, the Open Society Foundations, and local community foundations often grant funds to health initiatives, including those for addiction treatment.
   - Corporate Sponsorships: Businesses, especially those in the healthcare sector, may sponsor programs or donate funds as part of their corporate social responsibility initiatives.

D. Insurance Reimbursements
- Medicaid and Medicare: For eligible individuals, these government health programs can cover part or all of the costs of opioid addiction treatment, including outpatient and inpatient services.
- Private Health Insurance: Coverage for addiction treatment services can vary, but many private insurers cover treatment to some degree under behavioral health provisions, for which contracts would have to be negotiated.

E. Crowdfunding and Community Fundraising
- Online Fundraising Platforms: Sites like GoFundMe or Kickstarter can be used to raise funds for specific projects or expansions within treatment centers.
- Community-Based Fundraising Events: Local events such as charity runs, auctions, or concerts can raise funds and increase community awareness and support for treatment centers.

F. Public-Private Partnerships
- Collaborations Between Businesses and Nonprofits: Partnerships between private companies and nonprofit treatment centers can provide financial support, in-kind donations, or co-sponsored treatment programs.

G. Research Grants and Scholarships

- Academic and Research Institutions: Universities and research organizations often have funding available for programs that include a research component, helping to advance the science of addiction treatment and recovery.

H. Conclusion

- These funding sources are crucial for establishing and maintaining comprehensive treatment services, especially in areas heavily impacted by the opioid crisis like Las Vegas. Leveraging a combination of these funds can help ensure that treatment centers have the necessary resources to provide effective, ongoing support for individuals struggling with opioid addiction.

Call to Action

A. Introduction
- The success of a new opioid treatment center in Clark County hinges not only on the establishment of the facility itself but also on ongoing community engagement and support.

B. Community Awareness and Education
- Host Community Meetings: Organize town hall meetings to discuss the opioid crisis with residents, local businesses, and stakeholders, explaining how the new center will benefit the community.
- Educational Campaigns: Launch educational campaigns across various media platforms to raise awareness about opioid addiction, the importance of treatment, and the specific roles of the new center.

C. Advocacy and Policy Support
- Engage with Local and State Officials: Work with government officials to advocate for supportive policies and funding. This can involve arranging meetings, providing briefings, and encouraging community members to reach out to their representatives.
- Policy Development Workshops: Organize workshops to help stakeholders understand and influence the local policies affecting opioid treatment and funding.

D. Financial Contributions and Fundraising
- Fundraising Events: Plan and host fundraising events such as charity runs, galas, or concerts to raise funds for the center.
- Online Fundraising Campaigns: Use platforms like GoFundMe to create and promote online campaigns that can reach a wider audience.
- Corporate Sponsorship: Engage local businesses and national corporations to seek sponsorships or partnerships that provide financial support or services in kind

E. Volunteer Recruitment
- Recruit Volunteers: Encourage local residents to volunteer at the center, whether in direct care roles (for those qualified) or in supporting functions like administration, outreach, and event management.
- Professional Services: Seek professionals willing to donate their skills and time, such as counselors, doctors, nurses, and social workers.

F. Building Partnerships
- Collaborate with Healthcare Providers: Form partnerships with local hospitals, clinics, and health professionals to ensure a continuum of care for patients.
- Partner with Nonprofits and Community Groups: Work with existing organizations focused on drug addiction, health care, and social services to create a network of support for the center's clients.

G. Continuous Improvement and Feedback
- Community Feedback Sessions: Regularly hold feedback sessions with treatment center clients and community members to hear their experiences and suggestions for improvement.
- Ongoing Assessment and Adaptation: Continuously assess the effectiveness of the center and adapt strategies in response to changing needs and feedback.

H. Public Commitment
- Sign a Community Pledge: Create a pledge that local businesses, leaders, and residents can sign to show their commitment to supporting the opioid treatment center and its goals.

I. Media Engagement
- Press Releases and Media Briefings: Use media relations to keep the community informed about the progress and successes of the treatment center, as well as ongoing needs and challenges.
- Social Media Campaigns: Leverage social media platforms to keep the conversation going, share success stories, and highlight the importance of community support.

J. Conclusion

- Implementing these actions requires coordinated efforts across various sectors of the community. By engaging a wide array of stakeholders and maintaining transparent, open communication, the establishment of a new opioid treatment center in Las Vegas can be a cornerstone in the fight against the opioid crisis, leading to significant health and social benefits for the entire community.

Conclusion

A. Summary

- The establishment of a new opioid treatment center in Clark County represents a crucial step towards addressing the severe impact of the opioid crisis in the area. With escalating rates of addiction and overdose deaths, particularly those involving potent substances like fentanyl, the need for comprehensive, accessible treatment options is more pressing than ever.

B. Key Points Summary

- Enhanced Accessibility and Specialization: The center will provide critical services that are currently in high demand, including detoxification, medication-assisted treatment, and comprehensive behavioral therapies. Specialized programs can address the needs of diverse populations, including youth, veterans, and pregnant women, ensuring that all community members have access to tailored support.
- Community and Economic Benefits: Beyond health improvements, the center is expected to contribute to public safety and economic stability of Clark County. By reducing the incidence of drug-related crime and improving the overall health of the population, the center can alleviate the economic burden on local healthcare systems and boost community productivity.
- Education and Prevention Initiatives: The center will also play a vital role in prevention efforts through community education and awareness programs designed to reduce stigma and inform the public about the dangers of opioid misuse.

- Collaborative Efforts for Sustainability: Success hinges on the collaborative efforts of various stakeholders, including healthcare professionals, government agencies, private organizations, and the community at large. Ongoing support through funding, volunteering, and policy advocacy will be essential for the center's sustained impact.

C. Final Thoughts

- The proposed opioid treatment center is not just a response to a crisis—it is an investment in the future health and well-being of Clark County. By addressing this pressing public health issue, the community can foster a safer, healthier environment for all its members. It's a call to action for everyone in the area to support a project that has far-reaching benefits, from immediate health improvements to long-term social change. Through united efforts and continued commitment, Clark County can serve as a model for effectively combating the opioid epidemic and improving public health outcomes across the nation. This conclusion aims to galvanize support and underline the broad impact that such a facility could have, not just on individuals struggling with addiction, but on the community as a whole.

Q&A

Appendix U

BJA's Comprehensive Opioid, Stimulant, and Substance Abuse Program

Overdose Fatality Review

A Practitioner's Guide to Implementation

Acknowledgment

This document was authored by Melissa Heinen and Mallory O'Brien, Institute for Intergovernmental Research.

Financial support for this toolkit was provided by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice and the U.S. Centers for Disease Control and Prevention.

Released: July 2020

Learn more about the Overdose Fatality Review at **www.cossapresources.org**.

About BJA

The Bureau of Justice Assistance (BJA) provides leadership and services in grant administration and criminal justice policy development to support local, state, and tribal law enforcement in achieving safer communities. To learn more about BJA, visit www.bja.gov and follow us on Facebook (www.facebook.com/DOJBJA) and Twitter (@DOJBJA). BJA is part of the U.S. Department of Justice's Office of Justice Programs.

This project is supported by the Bureau of Justice Assistance (BJA), Office of Justice Programs, U.S. Department of Justice, and the U.S. Centers for Disease Control and Prevention by Grant No. 2017-AR-BX-K003 awarded by BJA. The contents of this document were developed by the Institute for Intergovernmental Research and do not represent the official position or policies of the U.S. Department of Justice or the U.S. Centers for Disease Control and Prevention.

Table of Contents

Overview

Overview

What Is the Overdose Epidemic?

Drug overdoses are a leading cause of death in the United States. From 1999 to 2017, more than 702,000 people died from a drug overdose in America; 67,000 died in 2018.

Pointing to progress in addressing the epidemic, there were 4 percent fewer overdose deaths in 2018 compared with 2017.

Are Overdose Deaths Preventable?

Yes. Overdose deaths can be prevented with coordinated prevention strategies, timely implementation of evidence-based interventions, community mobilization, and supportive families and friends.

The shared understanding that overdose deaths are preventable guides the entire overdose fatality review (OFR) process. Federal agencies, such as the Bureau of Justice Assistance (BJA) and the Centers for Disease Control and Prevention (CDC), are strategically coordinating to mobilize local communities to develop and implement OFRs.

What Is an Overdose Fatality Review (OFR)?

The purpose of an OFR is to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies.

In practice, OFRs involve a series of confidential individual death reviews by a multidisciplinary team. A death review (also referred to as a "case review") examines a decedent's life cycle in terms of drug use history, comorbidity, major health events, social-emotional trauma (including adverse childhood experiences), encounters with law enforcement and the criminal justice system, treatment history, and other factors, including local conditions, to facilitate a deeper understanding of the missed opportunities for prevention and intervention that may have prevented an overdose death.

By conducting a series of OFRs, jurisdictions begin to see patterns of need and opportunity, not only within specific agencies but across systems.

Blending input from public health, public safety, providers, and the community, OFR teams develop program and policy recommendations to improve coordination and collaboration between agencies and community conditions to prevent future overdose deaths.

These recommendations are presented to a governing committee that supports and provides resources for implementation and a framework for accountability for action. Examples of successful recommendations include the integration of peer recovery specialists into new settings, targeted naloxone distribution, and improved coordination of public safety and public health.

Why Are OFRs a Useful Strategy for Preventing Overdose Deaths?

Fatality reviews are used to address several complex public health issues. Reviews such as homicide, child death, maternal mortality, critical incidents, suicide, and

overdose deaths share many common components such as a focus on prevention, convening of multidisciplinary teams to do a series of case reviews, identification of missed opportunities for prevention and intervention, and development and implementation of data-driven prevention and intervention strategies.

The OFR process generates information about the decedent and his or her interactions with services and systems. This information is used to craft recommendations to prevent future similar deaths.

Toolkit Design

As a nationally recognized model, OFR is being used by a growing number of communities to strengthen their community-based responses to the opioid overdose epidemic. This toolkit is a companion document to the CDC Foundation's Public Health and Safety Team (PHAST) Toolkit and was created to help communities plan, implement, and evaluate OFRs. It is designed for multiple audiences including public health, public safety, criminal justice, drug treatment, and social services.

The goal of the toolkit is to provide the reader with the needed information to build a successful OFR process with a strong foundation in coalition, data collection, and prevention. The toolkit content draws on other fatality reviews and the authors' practice-based knowledge. It is organized into five modules:

Module 1. Recruit Your OFR Members

Recruit Your OFR Members

Module 1

This module covers the overdose fatality review (OFR) team leadership roles and members, as well as how to recruit to ensure active participation by multidisciplinary members. It also covers how the OFR team fits into a larger infrastructure, including subcommittees and a governing committee.

1A. OFR Team

OFR teams are multidisciplinary and include individuals who can share information about a decedent or contribute to the analysis of available data to make recommendations that will prevent future overdose deaths.

Like the CDC Foundation's Public Health and Safety Team (PHAST) framework, an OFR encourages multisector collaboration by using the data-driven "SOS" process. In this context, SOS stands for shared understanding, optimized capacity, and shared accountability.

OFR Team Members

Overdoses affect a variety of populations, neighborhoods, and communities. To effectively function and work toward the goal of preventing overdose deaths, OFR teams need a diverse set of members from disciplines and sectors that represent the community.

S **Shared understanding.** OFRs increase members' understanding of area agencies' roles and services as well as the community's assets and needs, substance use and overdose trends, current prevention activities, and system gaps.

O **Optimized capacity.** OFRs increase the community's overall capacity to prevent future overdose deaths by leveraging resources from multiple agencies and sectors to increase system-level response.

S **Shared accountability.** OFRs continually monitor local substance use and overdose death data as well as recommendation implementation activities. Status updates on recommendations are shared at each OFR team meeting and with a governing committee, reinforcing accountability for action.

Finding the appropriate partner agencies and professionals to become OFR team members is essential in establishing an effective OFR. It is important to partner with agencies willing to:

- Provide quality services.
- Develop successful partnerships.
- Maintain consistent engagement.
- Be good stewards of data—following confidentiality.
- Engage in public policy or advocacy.

Each partner agency should identify staff members (frontline staff, mid-level supervisors, or executives) who have the most appropriate roles within in the agency to be OFR team members and who regularly attend and contribute to the OFR. All staffing levels are important and needed on a review team to ensure the most complete understanding of how agencies and systems work together, including what gaps exist and what steps may be needed to implement identified prevention recommendations. This level of engagement ensures that at least one person from each agency can be present at each meeting and helps build internal agency relationships and champions for change.

OFR team members are dedicated professionals who believe that overdoses are preventable, are well-regarded in the field, and have time to attend regular meetings and participate in follow-up activities. Effective OFR teams have 15-35 members. A list of typical OFR team members is available in Figure 2.1.

Some sectors, such as law enforcement agencies, may have more than one representative on OFR teams. For instance, if there are multiple law enforcement agencies (sheriff's office, police department, etc.) in your jurisdiction, you may have both a sheriff's office and a local law enforcement representative.

For some cases, OFR team members may have had previous contact with a decedent or the decedent's family or social network. They may also represent an agency

Figure 2.1 Typical OFR Team Members

- Local health department official
- Local law enforcement representative
- Medical examiner/coroner
- Prosecutor
- Local human services department official
- Substance use treatment provider
- Medication for opioid use disorder (MOUD)* provider*
- Mental health social worker
- Pain management clinician
- Emergency department physician
- Primary care provider
- Pharmacist/toxicologist
- High Intensity Drug Trafficking Area (HIDTA) public health analyst
- Sheriff
- Probation and parole office
- Emergency medical service provider
- Drug treatment court representative
- Patient advocate
- Child protective services representative
- Substance use prevention professional
- School counselor
- Tribal elder, traditional leader
- Community leader
- Housing authority representative
- Harm-reduction outreach professional

* formerly known as medication-assisted treatment (MAT)

that provided services to the decedent or where the decedent lived, or where the overdose incident occurred.

The OFR team members provide essential information about the conditions or environments in which the decedent was born, lived, worked, and aged and what may have contributed to the decedent's overdose death.

Some Environmental and Social Determinants Contributing to Fatal Overdose

- **Environmental factors** that may have contributed to the overdose incident. For example, the decedent may have lived in a home with violence and drug use, or police officers had responded multiple times to the decedent's apartment building regarding complaints of drug dealing and loitering.
- **Social determinants** of health, which are the social and community networks and the socioeconomic, cultural, and environmental conditions in which residents live, as well as the health and social systems available. Every community has assets and needs that impact the health status of its residents.
  - **Community assets** that promote social inclusion and that may improve the community's health and well-being to help prevent future overdose deaths, such as a robust public transportation system, adequate housing for low-income households, and transitional housing and shelters available without a long wait to those in need.
  - **Community disadvantages** that increase the community's risk for substance use and overdose deaths, such as a high unemployment rate, systemic racism, lack of substance use treatment providers, and frequent drug arrests and drug-related crime.

Tip: Consistent attendance builds trust among participants.

Social determinants of health

Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

– Healthy People 2020

In addition to possibly providing services to the community and to the decedent, an effective OFR team member will also have:

- An understanding of the impact of the overdose epidemic in his or her community.
- The ability to assess problems at the macro or system level and assess organizational practices or communitywide initiatives.
- Authority to make decisions for the agency he or she represents or direct access to decision makers.
- The ability to critique work of other agencies and raise questions without passing judgment.

OFR Team Member Attendance

Encouraging OFR team members to attend each OFR is important, even if a fatality is not from their geographic territories, populations, or issues of focus. It helps to build rapport and builds trust within the team. This trust allows for more open dialogue about each case and increases commitment to recommendations. In addition, members often have critical knowledge outside their geographic areas or substantive focus where decedents and their social networks may travel across jurisdictions.

Missing even one meeting can impact the team dynamics and members' understanding of the overdose issues and prevention strategies. If a member cannot attend, he or she may send a pre-approved designee.

Tip: OFR teams may benefit from inviting guest participants to contribute information to specific cases; such participants are known as OFR guest members.

OFR Guest Members

An OFR meeting may focus on cases from a specific area in a geographic region where nonprofit agencies, faith-based organizations, and other community leadership or service agencies that are not consistent OFR team members can inform problem-solving-discussions and formulate realistic and community-specific prevention recommendations. These OFR members are known as guest members.

In addition, agencies that, and individuals who, have directly or indirectly served an overdose decedent may have valuable information. As such, they may be invited to attend as guest members. Guest members representing agencies with information about the decedent may be identified from news coverage about the death or from medical examiner/coroner reports.

Participants from smaller nonprofit organizations or understaffed organizations may have less time to prepare for reviews, have fewer staff members to send if key staff members are unable to attend, require more reminders of meetings and tasks, and need more support implementing recommendations targeting their agencies. You may consider asking such members to serve as guest members only for specific cases to ensure that they obtain the maximum benefit possible.

Another example of a guest member is an elected official or someone who wants to observe and learn more about the OFR process.

1B. OFR Leadership Roles and Structure

Every OFR team has a lead agency that oversees the OFR team and provides administrative support. The lead administrative agency has an institutional commitment to preventing overdose deaths and providing resources, and staff to support the initiative. It is seen by the community as a trustworthy and collaborative agency.

An OFR lead agency can be the local health department, human services department, prevention coalition, or other local agency and is seen as a neutral agency; typically, this agency is already involved as a leader in responding to the overdose epidemic.

The OFR lead agency oversees the OFR team by providing administrative support to fulfill three key leadership roles:

- Facilitator
- Coordinator
- Data manager

The OFR team leadership structure and roles depend on the jurisdiction. Jurisdictions with significant financial and political support may have up to three separate funded staff positions. In other jurisdictions, one person completes the roles.

1C. OFR Team Facilitation Role

A representative from the lead agency should serve the facilitation role. The OFR team facilitator is responsible for activities such as:

- Facilitating OFR meetings
- Recruiting OFR team members
- Building and maintaining relationships with OFR team members
- Orienting new OFR team members

Facilitating OFR Meetings

OFR team meetings are facilitated using a problem-solving process to identify recommendations and to track and oversee implementation of developed recommendations. More information about the OFR team facilitation role is available in Module 3. Facilitate Your OFR Meeting.

Figure 2.2 Key Leadership Roles and Responsibilities

Facilitator	• Facilitate OFR meetings • Recruit OFR team members • Build and maintain relationships with OFR team members • Orient new OFR team members
Coordinator	• Obtain and share case information with team members • Review data and reports from team members • Research information about cases that may not be provided by OFR members, such as reviewing social media, obituaries, media coverage, etc. • Draft OFR meeting agendas, in partnership with the OFR team facilitator • Manage meeting logistics (such as date and time, location, and technology support) • Take minutes during each meeting • Document activities since the last OFR meeting • Update the governing committee • Support and communicate with subcommittees
Data Manager	• Enter case information and recommendations into OFR database • Write data or summary reports for sharing with the OFR team and the governing committee • Analyze OFR data

Recruiting OFR Team Members

OFR teams benefit from ongoing recruitment of new members to address staff turnover, address gaps in their membership, or identify new trends.

Members may need to be recruited and engaged before being requested to provide data, participate in a review, or assist with developing or implementing a recommendation. Their perspectives and input will be valuable even if their organizations did not have direct contact with the decedent or service area related to the case. For example, a drug treatment provider has a valuable perspective on standards of care even if it did not provide services to the specific individual being reviewed. A toxicologist or pharmacist may assist with understanding the prescription drugs provided to the decedent even if he or she did not interact with that individual.

Effective recruitment is all in the details. Ideally, the OFR team facilitator will meet one on one with new recruits to prepare members for what to expect when participating on a review team by:

- Explaining the OFR goals and reviewing overall structure.
- Sharing stated and unstated group rules/norms.
- Emphasizing that the purpose of the meeting is not to point fingers at other participants.
- Addressing any data sharing or confidentiality concerns and having them sign a confidentiality agreement. A sample confidentiality agreement is included in Appendix D.

Tip: Partnerships are fundamental to the success of the OFR. Visit the CDC Foundation's **PHAST Toolkit** to learn more about building multi-sector partnerships.

- Summarizing past and current recommendations relevant to their organization or area of work.
- Suggesting immediate ways they can participate in developing and implementing a recommendation.

Drafting an OFR recruitment email with the above information, a meeting schedule, and a clear list of partner expectations will help communicate and recruit new active members. A sample OFR recruitment letter is included in Appendix A.

Before recruited members can participate on the review, they will need senior leadership to sign an interagency agreement. A sample interagency agreement is included in Appendix D. Depending on whether your state has OFR-specific legislation, memoranda of understanding (MOUs) from data providing members may be needed.

Building and Maintaining Relationships

Building and maintaining relationships can be achieved several ways. For example, the OFR team can use meeting breaks as an opportunity to incorporate team building.

This may involve as little as pulling aside a couple of participants and introducing them to each other and bringing up a shared interest or connection they may not be aware of. Encouraging members to stay after the meeting to network is another effective way to build trust and relationships.

A more formal way to help build team cohesion is to provide general agency or member updates at the beginning or end of the meeting that may result in partnerships during and outside of the fatality review experience.

Keep in mind that if the relationship with the agency is new, attending agency events and asking to observe the program may help you to get a sense for what the agency does and will build rapport.

Orienting New OFR Team Members

Every team member will come to the table with different experiences, knowledge, prejudices, and ideas about substance use and its impact on his or her work and the community. It will be the facilitator's responsibility to lead meetings in a way that elevates all voices, addresses stigma or misinformation, and neutralizes tensions. To prepare for this task, the team facilitator may expect each member to obtain certain knowledge or training ahead of participating in an OFR team meeting.

Recommended trainings include the following:

- "Partnerships for Prevention: OFR 101" webinar (link to COAP resource)
- "Overcoming Stigma, Ending Discrimination" (https://www.samhsa.gov/power-perceptions-understanding/webcasts)
- "Why Addiction Is a 'Disease' and Why It's Important" (https://www.samhsa.gov/power-perceptions- understanding/webcasts)
- "Social Determinants of Health: Know What Affects Health" (https://www.cdc.gov/socialdeterminants/index.htm)

Tip: The OFR team facilitator needs to attend and support partners' events and initiatives.

- "Words Matter: How Language Choices Can Reduce Stigma" (http://latwc.org/uploads/3/4/8/2/34828545/session_101_ho3_words_matter_tot_binder.pdf)

Since death investigations vary by jurisdiction, it may be beneficial for OFR team members to learn more about the local death investigation process and the roles they play with information available from the medical examiner's/coroner's office and local law enforcement agencies.

1D. OFR Team Coordination Role

A representative from the lead agency should serve the coordination role. The OFR team coordinator is responsible for activities such as:

- Obtaining and sharing case information with team members
- Receiving data and reports from team members
- Researching information about cases that may not be provided by OFR members, such as reviewing social media, obituaries, media coverage, etc.
- Drafting OFR meeting agendas, in partnership with the OFR team facilitator
- Managing meeting logistics (such as date and time, location, and technology support)
- Taking minutes during each meeting
- Documenting activities since the last OFR meeting
- Updating the governing committee
- Supporting and communicating with subcommittees

More information about the OFR team coordination role is available in Module 2. Plan Your OFR Meeting.

1E. OFR Data Manager Role

A representative from the lead agency should serve in the data manager role. The OFR team data manager is primarily responsible for entering case information and recommendations into the OFR database.

Governing Committee:

The governing committee provides direction to the OFR team and resources to implement the recommendations generated.

More information about the OFR data manager role is available in Module 4. Collect Your OFR Data and Module 5. Build a Recommendation Plan.

In addition to entering data, there may be a need for analyzing data from other data sources and/or the OFR case data for OFR team meetings, governing committee updates, and annual reports.

1F. OFR Subcommittees

The bulk of the work of an OFR may occur between meetings at the subcommittee level. Subcommittees may determine case selection criteria or how a recommendation may achieve a policy change. For example, if an OFR review identified improving care coordination among inpatient and outpatient treatment providers as a need, a subcommittee of local treatment providers, social workers, and patient advocates might convene to discuss gaps in care; identify partner agencies; and develop recommendations, an implementation plan, and a timeline for completion.

Subcommittee membership may include members of the governing committee, the OFR team, and outside experts (e.g., experts related to addiction, homelessness, veterans' affairs, or family survivors).

Subcommittees meet separately from the OFR team and report to other members at case review meetings on their aims and progress. Subcommittees are formed and disbanded as needed, so they may serve an

ongoing or a temporary purpose. To learn more about forming a subcommittee to develop a recommendation, review Section 5C. Form a Subcommittee to Develop Recommendations.

1G. Governing Committee

In addition to the lead agency and subcommittees, the OFR team needs a committee to provide leadership and support for implementing recommendations it has identified. This committee is referred to as a governing committee.

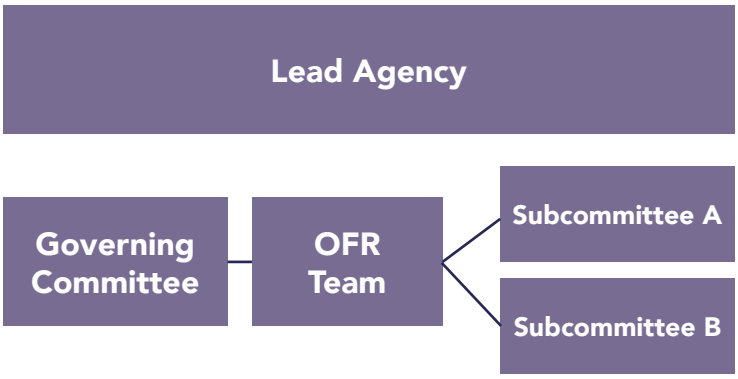
Depending on the jurisdiction, the governing committee may be an already existing local drug prevention task force or may be formed solely to support the OFR initiative.

The governing committee is composed of senior-level representatives of city, county, and state agencies and community partner organizations. Table 1.1 lists possible governing committee members for a local OFR team. To learn more about how the OFR team interacts with the governing committee, review Section 3I. Updating the Governing Committee.

Table 1.1 Example of Governing Committee Members

- Chief of police
- Mayor
- Commissioner of health
- Researchers at a local university
- District attorney
- School superintendent
- Medical examiner/coroner
- Chief executive officers at local hospitals
- County sheriff
- Attorney General
- Secretary of Department of Corrections
- Behavioral health administrator

1H. OFR Overall Structure



Module 2. Plan Your OFR Meeting

Plan Your OFR Meeting

Module 2

This module will assist overdose fatality review (OFR) coordinators in planning OFR meetings and prepare partners to actively and thoughtfully participate in meetings.

2A. Meeting Logistics

Meeting Schedule

The meetings are held when and where most members can attend. The schedules and locations of the entire year's meetings should be developed at the beginning of the year so that OFR team members can plan accordingly.

A typical meeting will be two to three hours in length and each case will take about an hour, depending on the complexity of the case and the review team's experience.

Meeting Room Layout

The meeting room layout is important for group dynamics and inclusion. Hosting the OFR team meeting in a circle or a hollow rectangle layout gives everyone an equal position at the table and allows for face-to-face interactions by all participants. In addition to having adequate space for desired layout, it is ideal to have a whiteboard in the meeting room for taking notes and displaying the created timeline of significant life events leading up to the decedent's overdose death.

Tip: Having timely data is critical for a successful OFR initiative.

Remember: Each meeting attendee, including guest members or invited guests/observers, needs to review and sign appropriate confidentiality forms to attend.

Closed-Meeting Format

Given the sensitive nature of the information shared and the need to build trusted relationships, the OFR meetings are closed and not open to the public.

Sometimes, invited guests will participate or observe to learn more about OFRs. Most often, the invited professionals have information specific to the case and are called guest members.

2B. Meeting Preparation: Coordinator's Activities

Successful OFR case reviews depend on thoughtful preparation by the OFR coordinator, beginning a month or two before an OFR case review meeting. A list of coordinator activities and a timeline is provided below and in the Coordinator's Meeting Preparation Checklist provided in Appendix B.

1. Select cases

Beginning two months before the meeting, the cases to be reviewed at the upcoming meeting need to be selected.

Having timely data is critical for a successful OFR initiative. The medical examiner's/coroner's office can be an excellent source for identifying overdose cases and initial case information. If possible, have someone with access to the medical examiner's/coroner's data on the case selection subcommittee and the OFR team. Ideally, this person will gather information about overdose fatalities as they occur.

Once cases are identified by the medical examiner/coroner, allow enough time for toxicology results to be known and police officers to investigate an overdose before selecting the case for review. This will enable the data to be collected and organized for a more complete case review.

2. Case selection criteria

It may not be feasible for every OFR team to review every death in its jurisdiction. In this situation, the coordinator may task a subcommittee with developing case selection criteria and/or selecting cases.

To help select cases, the following may need to be decided:

- **Jurisdiction inclusion**—residents from the jurisdiction or deaths within the jurisdiction
- **Substances involved**—all overdose deaths or only deaths from a specific substance will be included, for example, opioid-involved deaths
- **Cause of death**—only unintentional overdoses; include all (suicides and undetermined deaths) overdoses, or drug-related injuries, such as car crashes or hypothermia complicated by opioid use
- **Cases under investigation**—exclude cases in which there is an open law enforcement investigation

Once the core case criteria are determined, further case selection criteria may be needed to narrow the selection of cases to a feasible number. Criteria may include the following:

- Geographical neighborhoods with high rates (e.g., cases from the northside neighborhood)
- Populations with recent increases in deaths (e.g., young adult white females)
- Substances involved in most recent overdose deaths (e.g., fentanyl)
- Populations with known system interactions that may benefit from review (e.g., overdose deaths after recent release from incarceration or treatment)

3. Recruit guest OFR members

Beginning six weeks before the meeting, the coordinator needs to identify guest members, in addition to OFR team members, that he or she needs to recruit.

Agencies that are not already OFR members and that may have provided services to the decedent (such as a behavioral health provider) or that serve the community in which the decedent lived, such as social services or housing and employment supports, may be recruited to participate in a specific case review. The agencies to participate may be identified from the medical examiner's/coroner's report or from news coverage about the death.

An email and follow-up phone call to discuss the OFR process and purpose can be an effective method for getting participation. It is important to share and review interagency and confidentiality agreements. Have the agreements signed before discussing details of the case or requesting case information. Sample recruitment letter and agreements are included in Appendix A and D.

4. Request case information

Once interagency agreements are in place and around a month before the meeting, case-specific information should be requested of all team members. The information should be protected in accordance with confidentiality standards. If possible, use an encrypted email to request information about the case.

The email requesting case information should include the decedent's information listed below and guidance on what information is requested from members, including what specific data members should report out. A sample OFR case email, a member's guide to collecting case information, and a list of agency-specific data elements is included in Appendix B.

Decedent information:

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

5. Send meeting reminder email

Two weeks prior to the review, an email including the following should be sent to OFR members:

- Brief summaries of cases
- List of meeting participants
- Meeting agenda
- Meeting date, time, and location

A sample two-week reminder email is included in Appendix B.

6. Summarize case(s)

Prior to the meeting, the coordinator will want to summarize in a PowerPoint presentation or handout additional information identified by reading the obituary, news coverage, or social media posts or by interviewing family members or social contacts to present during the case review. A template for creating and presenting a case summary is included in Appendix B.

7. Document activities since last meeting

Two weeks prior to the meeting, reach out and follow up with partner agencies that were responsible for previous action items or recommendations to get a status update to share during the OFR meeting.

OFR teams should consider having a standing agenda item to provide updates on action or tasks completed since the last meeting. Documenting and sharing this information helps build in accountability of all members and subcommittees.

8. Print agendas and meeting materials

The coordinator is responsible for developing the meeting agenda with input from the OFR facilitator, if this is a different person. More information on developing an OFR meeting agenda is located in Section 3C, and a sample meeting agenda is included in Appendix C.

The coordinator will print and bring agendas, handouts, data use agreements, and any other materials needed during the OFR meeting.

Reminder: Documents need to be saved in a secure, restricted-access folder. If copies of the summary information are distributed at the meeting, the facilitator is responsible for collecting them at the end of the meeting to ensure security and confidentiality.

2C. Meeting Preparation: Members' Activities

OFR members include OFR core team members and invited guests. Members may begin preparing a month prior to the review meeting.

The more prepared the members are, the more engaged they will be, resulting in a more comprehensive understanding of the incident and what could have been done to prevent it.

1. Receive and review the case information

Members will receive an email one month prior to the meeting containing the basic decedent information listed below. Most OFR meetings will cover more than one case.

Decedent information:

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

2. Consider implications

Members will want to think about each case and any implications it might have for their organizations or agencies and for public policies affecting specific target populations, neighborhoods or communities, and/or topic areas (such as co-occurring mental illness and substance abuse).

3. Identify agency's contact

Members will need to determine whether their organizations or agencies had contact with the decedents, decedents' families, or social networks, or whether they provided services to the neighborhoods where the decedents lived or where the incidents occurred.

Follow up with the OFR coordinator if more information is needed to determine whether your organization or agency had contact with or provided services to the decedent(s).

4. Prepare a summary

If a member's organization or agency had contact with someone involved in the case or the incident area, he or she should prepare a summary to verbally share during the OFR discussion.

There are no hard-and-fast rules about what information will be useful in identifying a problem and possible solutions to prevent similar overdose deaths from a systems perspective. However, preparing for the review by answering the questions provided by the coordinator, along with reading the basic decedent case information, is a good starting point.

Important: Before you draft a summary, review the signed data sharing agreement and confidentiality forms, as well as your organization's confidentiality policies.

A member's guide to collecting case information and agency-specific data element recommendations are available in Appendix B.

Some members may choose to read a prepared summary and others may choose to read from available case file. Ideally, OFR team members will bring their summary and records to be able to reference back to during the meeting to allow additional details to become available as the discussion progresses.

5. Participate in group discussion

At the review meeting, members will want to ask questions to clarify information and timeline, identify missed opportunities or gaps in services, and suggest strategies to prevent future deaths."

6. Take notes during the meeting

At the review meeting, it is fine to take notes of the discussion, observations, prevention activities, or strategies you want to remember for your agency. Do not document any identifying information about a case that would be considered confidential.

7. Invest in networking

Schedule your day so you can arrive early and stay a few minutes after the review to meet other team members. It is a good networking opportunity and a great way to continue the discussion with other colleagues.

Module 3. Facilitate Your OFR Meeting

Facilitate Your OFR Meeting

Module 3

This module will assist overdose fatality review (OFR) facilitators in effectively facilitating review meetings to build trust and identify recommendations to prevent future overdose deaths.

3A. Facilitator's Role

An effective facilitator is a neutral convener who is a good listener, develops trust with partners, encourages group participation and engagement, leads but does not direct discussion, and guides the group towards collective problem solving to craft recommendations.

Ideally, to maintain objectivity and a sense of equality among partnering agencies and members, the facilitator should be a representative from a neutral lead agency, such as local public health or community coalition, and will not report to a principal agency such as the police department, the mayor's office, or a behavioral health service agency.

Definition: The OFR team facilitator is a "neutral convener" who oversees facilitation of team meetings to collectively problem solve and identify recommendations to prevent future overdose deaths.

Tip: Including discussion about the decedent's associates and social connections can provide a more contextual understanding of the circumstances surrounding the overdose death.

3B. Guiding Principles

The facilitator is responsible for ensuring that members agree with the following guiding principles:

- The "North Star" (a shared goal of reducing overdose deaths)
- Overdose deaths are preventable
- Substance use disorder is a chronic, treatable disease
- Use of multisector data to inform response strategies
- Continually improve the OFR process and prevention activities

Visit the CDC Foundation's Public Health and Safety Team (PHAST) Toolkit to learn more about these guiding principles.

3C. Meeting Agenda

A successful OFR meeting will cover the following nine steps. A sample agenda can be found in Appendix B.

1. Opening remarks and introduction

This step should include member introductions, updates from previous meetings, upcoming events, data presentation, review case selection criteria, and other announcements.

- Member introductions: Attendees share their names, titles and their agencies' names and roles in preventing overdose fatalities.
- Updates from previous meetings: Members share status updates on any delegated action items or recommendations from previous meetings.
- Data presentation: At the beginning of the year, present an overview of the prior year's fatal and nonfatal overdose deaths. At each subsequent meeting, present the year-to-date number of overdose fatalities and any noticeable trends (e.g., changes by overall numbers, demographics, or substance type). Understanding overdose fatalities (e.g., who is at risk for an overdose and where overdose deaths are happening) requires an ongoing and real-time analysis of overdose trends. Using a standard report will help partners understand long-term trends in fatalities and allow them to plan and develop new strategies or modify existing ones. Data and analysis from these reports can also be invaluable for promoting public awareness and outreach, as well as for applying for grant funding. A sample summary data report is included in Appendix B. Also, refer to the CDC Foundation's PHAST for more guidance about presenting data at an OFR meeting.
- Review case selection criteria: If not all overdose deaths within a jurisdiction are being reviewed, remind the review committee about which criteria were used to select the case.

2. Goals and ground rules

The facilitator reads aloud the meeting goal(s), guiding principles, and ground rules included on the agenda handout. Ask participants whether they want to add any new ground rules.

- A sample list of ground rules is included in Appendix B.
- Guiding principles listed in Section 3B.

3. Confidentiality

The facilitator or coordinator collects members' reviewed and signed confidentiality forms and answers any related questions. Confidentiality is discussed in more detail in Module 4. Collect Your OFR Data.

- Confidentiality agreement: This essential form needs to be signed at the beginning of each review by the members present. A sample confidentiality agreement is included in Appendix D.
- If more than one case is reviewed at a meeting and some members arrive mid-meeting, the facilitator needs to make sure that they sign and submit the confidentiality agreement when they arrive.
- Interagency agreement: This agreement needs to be signed by senior leadership of each participating agency (including any ad hoc agencies) before they participate in any reviews. The agreement states the role of the agency in the reviews. A sample interagency data sharing agreement is included in Appendix D.
- The facilitator is responsible for reminding team members that the meeting is closed and that the information shared in the meeting shall not be discussed outside the meeting, as outlined in the agreements they have signed.

4. Case presentation

The facilitator presents the decedent's basic case information.

- The facilitator presents the case summary developed by the coordinator, as outlined in Section 2B. Coordinator's Activities, Step 6. Summarize Case(s).
- If each member is given a summary document, all documents should be collected at the end of the meeting.

5. Member report-outs

The facilitator calls on each member to share what he or she knows about the decedent, his or her social connections, and the overdose incident. The information shared helps members understand more about where the decedent lived, socialized, worked, and played to help identify risk factors and missed opportunities for prevention and intervention that may have contributed to the overdose death.

The facilitator calls on members to share their summary reports, as discussed in Section 2C. Members' Activity, Step 4. Prepare a Summary, starting with the medical examiner and first-responder agencies, to report out in reverse chronological order, for assistance with developing an incident timeline. The facilitator will then determine the best approach to receive report outs from the remaining members, based on the specific case.

6. Group discussion

The facilitator actively guides the group discussion by encouraging members to ask questions. The group discussion will clarify the timeline of significant life events and identify missed opportunities for prevention and intervention. The facilitator may want to use the strategies outline in Section 3D. Meeting Facilitation Strategies.

7. Case and timeline summarized

The facilitator summarizes significant case information and draws a timeline of key activities, ideally on a whiteboard.

8. Formulate recommendations

The facilitator leads a problem-solving discussion as outlined in Figure 2.1 to identify recommendations for change in practices or policies that may have prevented this overdose death and may prevent those in the future.

9. Summarize and adjourn

The facilitator reviews and clarifies actionable recommendations, assigns individuals responsible for any action items, reflects on the meeting's process and findings, and collects any participants' handouts containing case information.

- The facilitator recaps how the meeting went and relates today's review to other cases or to a larger context, such as by saying, "Today's case involved a heroin-laced fentanyl, and there has been an increase in such reported cases in recent months from this area of the city."
- The team determines whether the investigation is complete or whether more information is needed.
- Remind members of confidentiality and collect any papers with confidential information.
- Remind members of the time and location of the next meeting.

Figure 2.1 Problem-Solving Process to Identify Recommendations

Tip:

To have the most significant impact, recommendations should focus on:

- Improving service delivery and investigation.
- Changing agency policies and practices.
- Revising local ordinance or state legislation.
- Initiating or modifying community prevention strategies.

3D. Meeting Facilitation Strategies

An OFR meeting is a combination of information sharing, group brainstorming and problem solving, strategic planning, and decision making. The meeting facilitator actively participates in the discussion, moving it from information sharing to problem solving using the following strategies.

1. Thank members

Thanking members for their input and suggestions encourages participation by all who have relevant information.

2. Encourage person-first language and respect for the decedent and survivors

OFR teams have a responsibility to honor the decedent's life and to respect surviving family members and loved ones. This can be accomplished by:

- Protecting confidentiality of the case review proceedings.
- Using appropriate and sensitive language when discussing the case.
- Avoiding judgment of the decedent's decisions.
- Considering all factors that contributed to the decedent's substance use and overdose.
- Trying to understand the decedent's experience through his or her eyes.
- Holding a place at the table for the decedent or taking a moment of silence.

3. Summarize members' comments

To ensure that main points are heard, the facilitator may restate or summarize members' comments, when possible, making connections clearer and stronger between members' points and potential implications for changing a system.

4. Solicit a variety of solutions/ recommendations

Actively encouraging strategies beyond standard enforcement and intervention-centered approaches will steer the group towards more upstream or primary prevention activities.

5. Address misinformation

While the facilitator does not need to be an expert, he or she should identify and correct misinformation when apparent. If there is disagreement over the accuracy of a statement, it can be paused for further research after the meeting to shift the focus back to the task at hand. Attention to accurate information will inspire standards of information quality. This is important for the development of meaningful recommendations and can reduce stigma that is based on misinformation.

6. Acknowledge all potential solutions

The facilitator remains neutral by acknowledging and giving equal consideration to all suggested solutions and demonstrating how each suggestion is part of a continuum of response to prevent overdose.

7. Ask open-ended questions

Asking open-ended questions helps participants (1) understand the "bigger picture," (2) examine the underlying issue, and (3) develop their own solutions.

8. Ask clarifying questions

The facilitator may ask members to explain agency-specific or sector-specific acronyms or labels so that everyone understands the material being presented. It is best not to assume that people already know or understand information. Asking clarifying questions helps team members become familiar with the internal processes of different organizations.

9. Ask reflective questions

Pausing and asking reflective questions allows members to look at the case and information shared and to identify missing information or partners.

Questions that may be useful include "Do we have all the information we need to identify the problem or solution?" and "Are there any organizations missing from this discussion?"

10. Encourage all to participate

To reinforce that all members have equal value and voice regardless of title or professional experience, the facilitator may want to refer to everyone by their first names. In addition, the facilitator should call on members who are less engaged or who do not readily speak up during the meeting.

11. Ask for help

Encourage persons who or agencies that specialize in an area to help direct a discussion. They may help by framing the nature of the problem, summarizing the results of past initiatives, explaining a new concept or practice, or proposing possible future recommendations.

12. Encourage team building

The OFR team should use meeting breaks as an opportunity to incorporate team building. This may involve as little as pulling aside a couple of members and introducing them to each other, bringing up a shared interest or connection they may not be aware of. Another way to build team cohesion is to provide general agency or member updates at the beginning or end of the meeting that may result in partnerships during and outside of the fatality review experience.

13. Anticipate possible areas of tension or bias

Including in the ground rules how the team will address unprofessional or disparaging statements from others will build trust. It is important that everyone understand the need to stay focused on working together to identify possible strategies for preventing future overdoses.

14. Politely redirect members

If the conversation becomes repetitive or irrelevant, the facilitator should ask questions or change focus to keep the conversation moving forward. For example, if a member makes a comment such as "This overdose could never have been prevented," the facilitator should politely redirect members in a direction towards prevention. This may be as simple as saying, "While this case may be difficult to review, we have identified a few service gaps. Let's start with one of those and think about what improvements may benefit others."

15. Remind members of the "North Star" and guiding principles

For some members, considering an overdose death a preventable event may be a significant cultural shift. Reminding members to commit to a common goal or "North Star" to reduce overdose deaths can help ground all OFR team members. More information about guiding principles can be found in the CDC Foundation's PHAST Toolkit.

3E. Managing Difficult Conversations

Disagreements, arguments, competing agency interests, and other personal and professional conflicts need to be anticipated and resolved prior to or during the meeting so the discussion can feel safe and fruitful for everyone.

As with much of the OFR process, much of the work happens outside of the review meeting. It is often necessary for the facilitator to reach out to members after a meeting to address any conflicts that arise during the review process and, when the facilitator anticipates conflicts, to reach out ahead of the meeting to mitigate any possible conflicts.

Tip:

Remind members of guiding principles:

- The "North Star" (shared goal of reducing overdose deaths)
- Overdose deaths are preventable
- Substance use disorder is a chronic, treatable disease
- Use of multisector data will inform response strategies
- Continually improve OFR process and prevention activities

To help limit and manage difficult conversations, the facilitator may also want to:

Limit tension between partners

To help members collaborate, the facilitator may want to make such suggestions as, "Let's try to build a solution together that will meet everyone's needs." If there is competition between service agencies, it can be useful to highlight the value each organization brings to the table.

Notice possible political issues

In researching a case for the review meeting, the facilitator may notice something that could result in one agency being under fire. The facilitator should give the agency a heads-up prior to the meeting, setting up the conversation and expectations in a way that allows for respectful, honest transparent discussion to identify and correct any issues to mitigate future problems.

Be on alert for individual member triggers

If a member of the meeting said something that was obviously disrespectful, the facilitator will need to remind members to be respectful. If the statement was stated respectfully, but another member took offense or is sensitive to the statement, the facilitator might restate the comment in a way that decreases the negative impact and encourages problem solving and collaboration.

Put a conversation on hold until after a meeting/create a "parking lot"

Acknowledge when a conversation is drifting or irrelevant and ask that members put it on hold until after

the meeting. Sometimes, disagreements benefit from a pause, which provides an opportunity for additional research to inform conflict resolution. The facilitator can tactfully ask the members to pause the discussion and move on to the next case or agenda item.

Remain neutral and objective

It is very important that the facilitator remain neutral and objective. Do not take sides in the dispute. Instead, ask members to focus on the facts of the case and the goal of the review—to prevent future overdose deaths. The facilitator may need to end a possible escalating discussion by making a statement such as, "It appears we have reached a stalemate. Let's move on and discuss other issues that were identified."

3F. Measuring Meeting Success

The facilitator wants to make sure that meetings are as successful as possible. The OFR process is always evolving in response to members' needs and changes in data trends. In addition, the identified recommendations impact large system issues, and it may take time to effectively make noticeable improvements. Therefore, it may be helpful to have some short-term measures to determine whether the OFRs are successful.

How do you know if an OFR is successful?

- Agencies continue to send staff members to the reviews.
- Members contribute to the discussion.
- Members are open to feedback and are not defensive.
- Members come more prepared for each meeting.
- Members linger after the meeting has formally ended to network with other members.
- Members begin to see connections between seemingly unrelated overdose deaths and develop a shared analysis.
- Agencies report that the information is useful to their daily work.
- Each agency is working on at least one recommendation during the year.

In addition to the above measures of success, the facilitator will want to connect with members between meetings to get feedback on the overall OFR process and meetings and identify strategies for improvement.

3G. Meeting Notes

The coordinator typically takes notes during the review. If the OFR team does not have both a coordinator and a meeting facilitator, the facilitator will want to delegate someone to take notes during the OFR meeting.

Notes help to document tasks that need follow-up and to track recommendations. Sometimes, notes are summarized and included in future meeting handouts or meeting minutes.

3H. Post-Meeting Tasks

While the OFR meeting forms the foundation of the process, follow-up events are equally important. The meeting discussion, case information, and identified recommendations must be documented and momentum maintained.

Immediate post-meeting activities (on the same or next day) include the following:

1. Preparing meeting minutes and securely storing them electronically with the other case records. A meeting minute template is included in Appendix C.
2. Capturing the OFR case information that was shared and collected at the review meeting, often

using an OFR database. Learn more about the OFR database in Module 4. Collect Your OFR Data.

3. Working on follow-up activities and reaching out to any identified partner agencies.
4. Drafting and sending updates to the governing committee, as requested. More information about this task can be found in Section 3I.

3I. Updating the Governing Committee

Summarizing review activities to update the governing committee should be done after each review meeting. Most often, the OFR coordinator is responsible for communicating with the chair of the governing committee to determine what is expected from a report-out from the OFR team.

Depending on the jurisdiction's OFR structure, some governing committees receive updates annually on priority recommendations and implementation status of prior recommendations. Other governing committees may request more frequent updates on review activity and findings; for instance, on a quarterly basis.

An update may be a short summary on a standing agenda or a full-length presentation or report. A sample governing committee report is included in Appendix C.

3J. Preventing Case Review Burnout

Reviewing overdose fatalities can affect review team members emotionally and psychologically. These effects are known as secondary trauma. The effects can be reduced by:

- Inviting experts in secondary trauma to present to the team.
- Identifying and understanding attendee reactions to potentially upsetting information.
- Acknowledging that everyone experiences stress from reviewing overdose fatalities.
- Sharing professional self-care resources and strategies with team members.
- Reporting on and celebrating successes such as implemented recommendations generated by the OFR process.
- Reminding members of the purpose and effectiveness of OFRs.
- Allowing members to rotate out after a period of service to the team if requested.
- Recognizing many members of the OFR team are first responders, behavioral health, and health care providers and may have compassion fatigue.

Compassion fatigue is the emotional strain of working with those suffering from the consequences of traumatic events. First responders may experience compassion fatigue as a result of encountering repeated overdose cases.

Consider using "The Vicarious Trauma Toolkit" (U.S. Office of Justice Programs, Office for Victims of Crime) to address and prevent secondary trauma. (Source: https:// vtt.ovc.ojp.gov/what-is-vicarious-trauma)

Module 4. Collect Your OFR Data

Collect Your OFR Data

Module 4

This module will assist the overdose fatality review (OFR) data manager in securely collecting and storing relevant case review data.

4A. Confidentiality

Confidentiality is essential for successful overdose fatality reviews. It maintains the trust of participating members and of the community in the OFR process. The lead agency should check state law and consult its legal authority before starting an OFR process. All team members (including guest members and observers) must sign a confidentiality agreement to attend.

Relevant federal laws that affect data protections

OFR teams must understand and adhere to the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA; and 42 CFR) in addition to the confidentiality policies of other government-private institutions that serve children and other vulnerable populations to protect decedent information. Refer to the agency's record retention policy—what types of documents need to be retained and for what length of time.

Relevant state privacy laws

Many states have statutes and legislation supporting and guiding the OFR process and confidentiality, and every year more states introduce legislation to support and guide the review process.

Some states may have additional privacy laws for medical, substance use, and mental health records.

Interagency data sharing agreement

An interagency data sharing agreement is signed by the senior leadership of each participating agency/members (including any one-time members) that outlines the responsibilities of each party. In an interagency data sharing agreement, all parties agree to share certain information on an established timeline, adhere to certain data protection standards, and identify communication expectations. A sample interagency data sharing agreement is included in Appendix D. Interagency data sharing agreements should be updated annually and amended as new members are added to the OFR team.

Confidentiality agreement

A confidentiality agreement needs to be signed by members at the beginning of each review. This

agreement is at the person/participant level and includes the objectives of the OFR. It prohibits dissemination of information beyond the purpose of the review. A sample confidentiality agreement is included in Appendix D.

In addition to understanding federal and state laws around OFR and signing data sharing and confidentiality agreements, there are other steps needed to maintain confidentiality. It is recommended that you create a data sharing protocol for the distribution of case information and record-keeping expectations. A sample data sharing protocol is included in Appendix D.

When sharing any sensitive case-specific information outside of the meetings with any members, encrypt the emails or protect them with passwords. Hand delivery also maintains confidentiality.

4B. Data Collection Process

Before the Meeting: Data Collection Steps

The data collection process begins before the OFR meeting and is a key responsibility of the OFR coordinator. In addition to steps 4 and 6 (request case information and summarize case) of Section 2B. Meeting Preparation: Coordinator's Activities, the coordinator will want to be familiar with the type of information captured in the OFR database.

As documents and information are received, organize and save all files on a secure computer with restricted access. Examples of these data files may include the medical examiner's/coroner's report, the decedent's criminal history, signed confidentiality forms (collected from participants at the meeting), and all data collected prior to or at the review meeting.

Important: Save all case-related documents and information on a secure computer with restricted access.

Tip: Summarizing key activities along a timeline, ideally on a whiteboard, is a great way to focus the OFR team's discussion.

As mentioned in step 4 of Section 2C. Meeting Preparation: Members' Activities (Prepare a summary), members will need to prepare a summary to verbally share during the OFR discussion. A member's guide to collecting case information and agency-specific data element recommendations are available in Appendix B.

During the Meeting: Data Collection Steps

The data collection process during the OFR meeting happens as the members report out and ask questions. The designated note taker (often the coordinator) will want to be familiar with the OFR database to make sure to capture pertinent information discussed in the meeting.

The facilitator summarizes in chronological order any significant case details shared in the meeting and elicits a discussion to focus participants on identifying

Reminder: At the beginning of every OFR meeting, ask all members to sign and submit the confidentiality agreement, and remind team members that the meeting is closed and prohibits dissemination of information beyond the purposes of the review.

missed opportunities for prevention and intervention. Section 3C. Meeting Agenda provides details on the types of information shared and discussed in the OFR meeting.

After the Meeting: Data Collection Steps

The OFR team data manager is responsible for managing the collection and entry of the data on reviewed cases and developed recommendations. Depending on the size of the jurisdiction and the resources available, the OFR facilitator or coordinator may be responsible for this task. The individual responsible for entering data needs to ensure that the data is entered consistently and accurately.

After the meeting, all the data from the meeting needs to be entered into the OFR database; learn more about the database in Section 4C. OFR Database. The facilitator or data manager may need to follow up with members to get missing data or information that needs more research outside of the review meeting. Any additional information provided will need to be entered into the OFR database.

4C. OFR Database

The OFR database collects information about the cases reviewed and the recommendations developed. The OFR database needs to be secure and stored at a neutral agency. For consistency across cases and OFR teams, OFR teams may want to use the OFR database developed by the OFR National Data Workgroup. The OFR database is a REDCap database available to all OFR teams and contains four main sections:

1. OFR team meeting details
2. Decedent case information
   - Demographics
   - Cause of death
   - Overdose and death-scene investigation
   - Interventions following the overdose
   - History of life circumstances and immediate stressors before the overdose
3. Community context
4. Recommendations

To access and learn more about the **OFR database,** visit **www.cossapresources.org.**

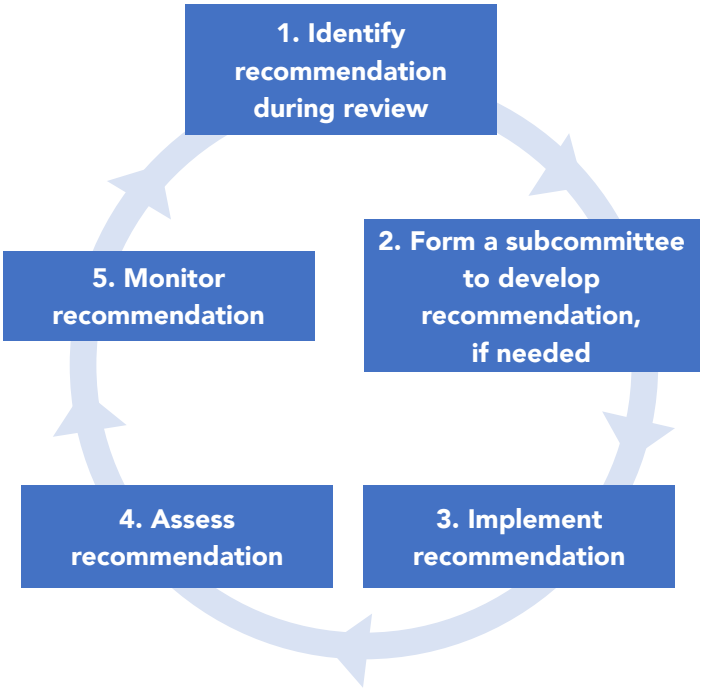
Module 5. Build a Recommendation Plan

Build a Recommendation Plan

Module 5

This section summarizes the types of recommendations that may be developed through the overdose fatality review process; provides an overview of the recommendation process, from developing to sustaining recommendations; and offers a method to track, monitor, and assess the implementation of recommendations.

Figure 5.1 Building a Recommendation Plan



5A. Identifying Recommendations During the OFR Review

The overdose fatality review (OFR) process is driven by an action-oriented partnership. Data comes from members representing multiple agencies. Each member gathers and provides potentially sensitive information to the team that informs the understanding of the overdose problem and potential solutions.

Successful OFRs rely on active engagement by members beyond the detailed case discussions, including formation, implementation, assessment, and continuation of prevention strategies. It is important that the OFR facilitator reinforce that recommendations can be identified and implemented through the OFR's collaborative, data-driven, problem-solving process. Learn more about this process in Section 3C. Meeting Agenda, Step 8. Formulate Recommendations.

Problem solving occurs during a collaborative process that fosters accountability and transparency. Identified solutions usually involve a cross-agency response that reduces duplication and information silos. The process is best served if it prioritizes addressing system issues and making recommendations for improvement.

Table 5.1 Recommendation Type

	Target Audience	Definition	Example
Systemic	Professionals, agencies, and organizations	Addresses a gap, weakness, or problem within a system or across systems	Improve communication between inpatient treatment providers upon discharge to an outpatient, medication for opioid use disorder (MOUD)—formerly known as medication-assisted treatment (MAT)—provider by establishing an automated alert system.
Agency-Specific	Only one sector or partner agency	Addresses a service gap or failure	Give naloxone to people who have been released from incarceration. Local health department to provide training to all hotel staff members on how to administer naloxone.
Research	Academic organizations and agencies that research overdose deaths or evaluate programs or policies	Recommendation to research a topic or issue area	Determine the number of deaths from prescription opioids for those who had a prescription for an opioid Establish a process for case review outcomes to inform research priorities.
OFR Quality Assurance	OFR team	Strengthen or improve the OFR process	Increase the length of meetings to allow for more time developing recommendations.
Population-Specific	Individuals and groups at increased risk	Evidence-based intervention that will reduce a specific risk factor for overdose	Increase access to buprenorphine among incarcerated populations.

Types of Recommendations

OFR teams may generate a variety of recommendation types across the continuum of care or systems as outlined in Table 5.1 Recommendation Type.

5B. Documenting Recommendations

The OFR initial recommendations are captured in the meeting minutes and in the recommendations section of the OFR database. More detailed recommendation-related information captured in the OFR database includes:

- A public summary of the recommendation
- A working summary of the recommendation
- Date recommendation identified
- Cases related to the recommendation
- Data sources shared at the review meeting
- OFR members present at the review meeting
- Type of recommendation (e.g., agency-specific or research-related)
- Level of prevention
- Population or issue of focus
- Jurisdiction level responsible for implementing the recommendation
- Agency responsible for implementing the recommendation and contact information
- Status of the recommendation
- Recommendation strategies (short-, medium-, and long-term)
- Recommendation implementation accomplishments
- Notes regarding any media coverage

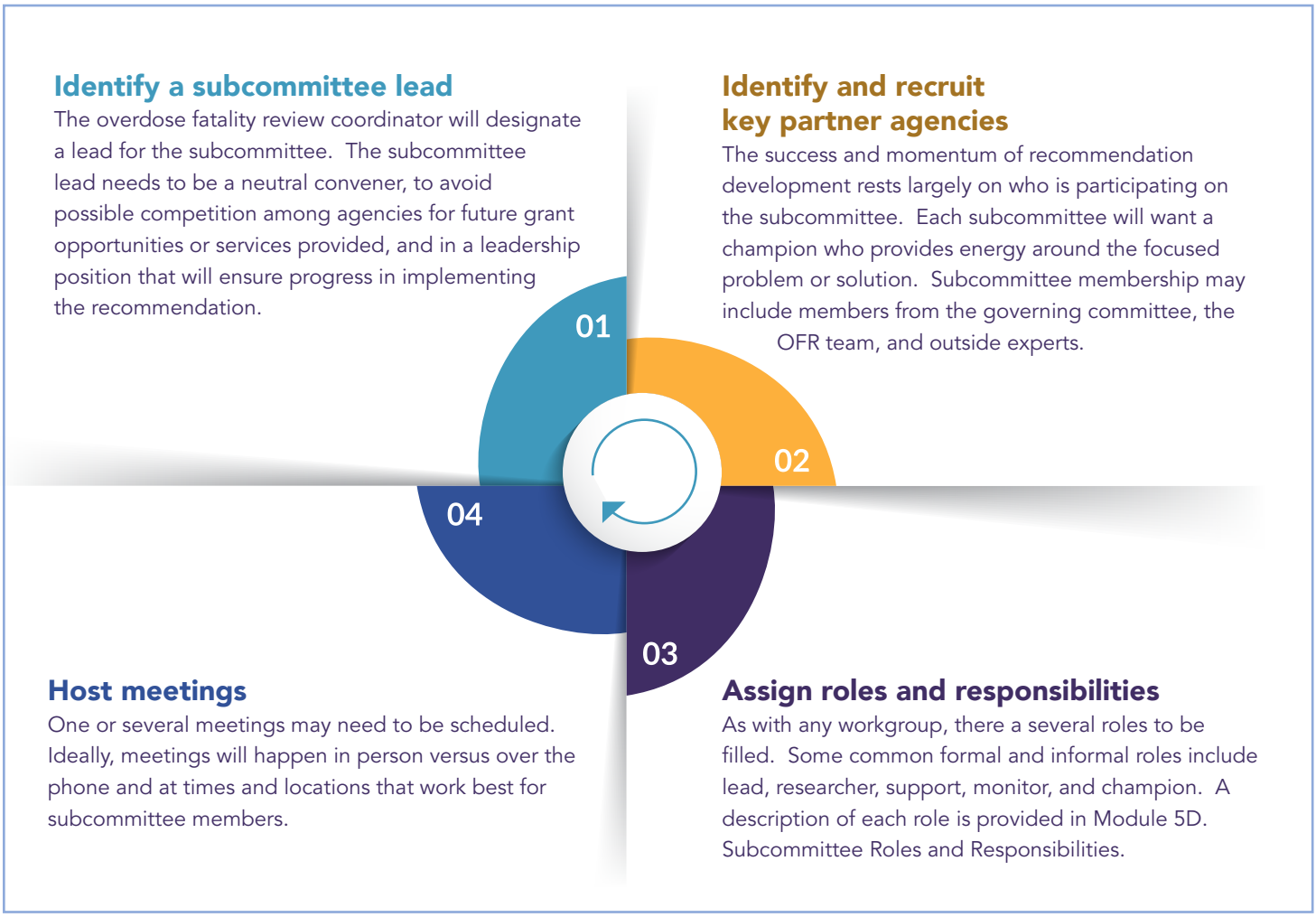
5C. Forming a Subcommittee to Develop Recommendations

Recommendations can be diverse, and some are easier to implement than others. Planning and implementing recommendations is a very rewarding process that can have immediate and tangible results. Some recommendations maintain momentum, and others may slowly lose support. The process can be challenging when factors outside of the OFR team's control impact progress. Creating subcommittees to focus and implement specific recommendations can maintain momentum by building sustained internal and external support for the strategy.

Subcommittees assigned to lead the development and implementation of a recommendation will want to follow the steps outlined in Figure 5.2 Forming a Subcommittee:

Reminder: Subcommittees meet separately from the OFR team and report out at case review meetings on their aims and progress. Subcommittees are formed and disbanded as needed, serving temporarily or on an ongoing basis.

Figure 5.2 Forming a Subcommittee



5D. Subcommittee Roles and Responsibilities

It takes multiple stakeholders to effectively develop, implement, and monitor recommendations. This section reviews the OFR coordinator's, facilitator's, and subcommittee members' roles and responsibilities regarding recommendations.

OFR coordinator and facilitator roles and responsibilities

The process for developing and implementing recommendations is collaborative and fluid. Success is possible only with open communication, timely information sharing, and trust building. Trust must be established in both the process and the other agencies involved.

The OFR coordinator must be able to manage competing agendas, interagency conflicts, and unpopular or criticized recommendations and to ensure partners that the process is fair, data-driven, and likely to produce results.

The OFR coordinator is responsible for designating the subcommittee lead, recruiting participants, supporting the subcommittee as needed, and checking regularly with the subcommittee on the status of the development and implementation of recommendations.

The OFR facilitator is responsible for developing trust and collaboration through the entire OFR process; both are crucial to successfully implementing recommendations.

Subcommittee members' roles and responsibilities

- **Lead**—The OFR coordinator assigns the subcommittee lead. The lead is responsible for setting the agenda, facilitating subcommittee meetings, taking notes, sending reminders, monitoring activities, and reporting to the OFR facilitator and others as identified (such as the governing committee or the OFR team).
- **Researcher**—The OFR coordinator designates a team member to present data trends such as overdose deaths, substances, hot spots, and related prevention and risk factors, as well as policy, practices, or procedures for a system or agency. This information helps inform decisions and guide the implementation of recommendations.
- **Supporter**—The OFR coordinator designates a supporter to provide minimal informal support as requested from the subcommittee. Examples of support may be connecting the subcommittee with an individual or an agency, finding meeting space, or reviewing draft materials.
- **Monitor**—The OFR coordinator works with the subcommittee lead to systematically monitor the implementation of a recommendation, ensure that it is addressing the problem it was intended to resolve, suggest refinements, ensure the status of the recommendation is tracked in the OFR database, and periodically report results to the OFR team and/or the governing committee.
- **Champion**—Any member who provides motivation, political will, and energy around the focused problem or solution is a champion.

5E. Implementing a Recommendation

Once the subcommittee has developed a recommendation, it needs to be implemented. It is important to do so strategically. The subcommittee lead may consider sharing recommendation materials with persons not on the subcommittee for their review and feedback.

The subcommittee must develop a work plan for implementing the recommendation.

Develop a work plan

The subcommittee is responsible for developing a work plan that:

- Identifies key action steps needed to implement and monitor the recommendation.
- Assigns responsibility to members and partners.
- Determines intermediate measures of success.
- Establishes a realistic timeline for completion.

A sample recommendation work plan is included in Appendix E.

5F. Assessing and Monitoring Recommendations

Plans for assessing and monitoring recommendations need to be developed at the beginning of the initiative. Steps for regularly updating and tracking the status of recommendations include the following:

1. Giving status updates

The subcommittee lead will check regularly with subcommittee members on the status of assigned tasks and implementation.

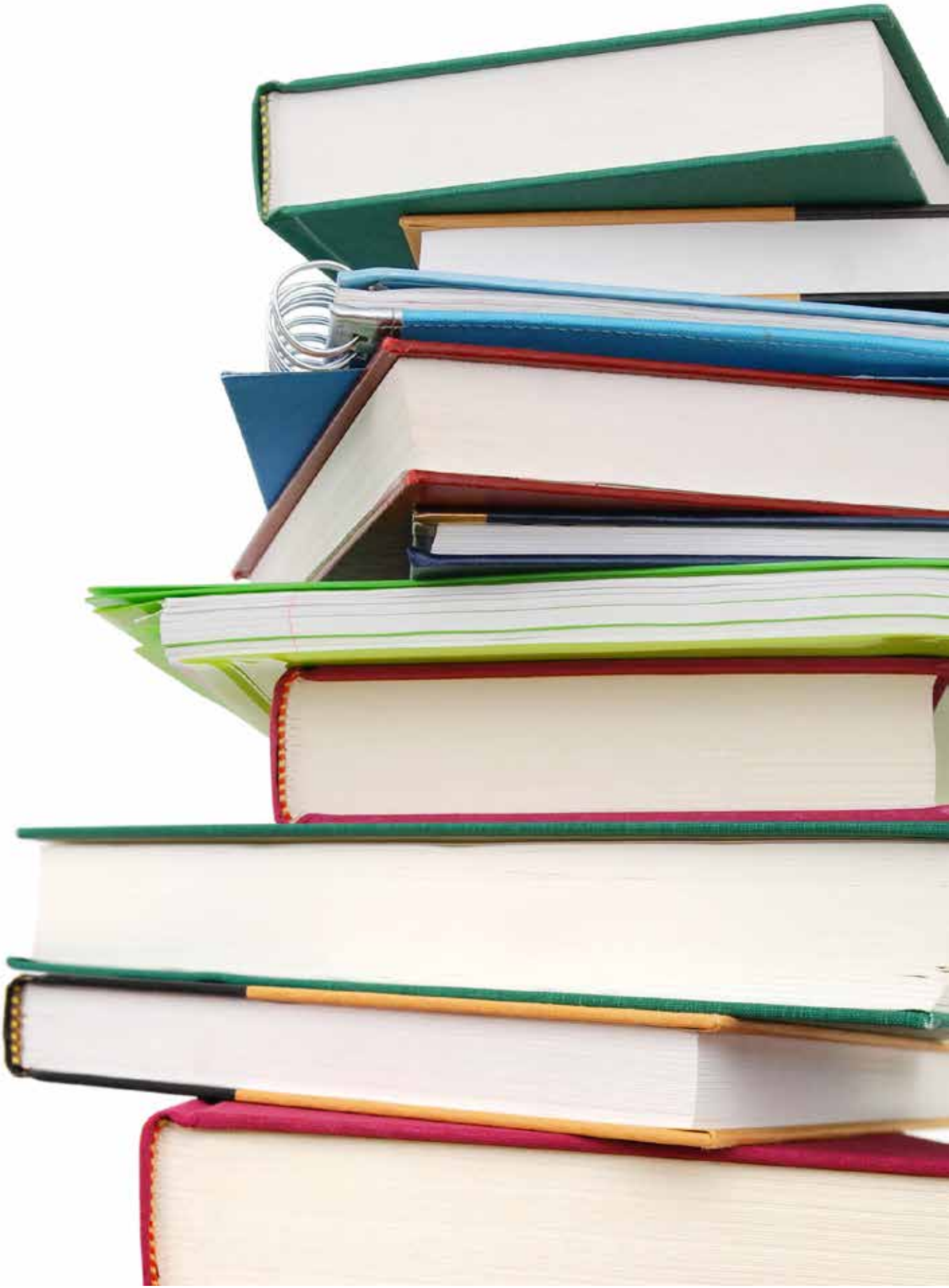
2. Reporting to the OFR coordinator

Prior to each fatality review and scheduled governing committee meetings, the subcommittee lead will provide the OFR coordinator with status updates on the implementation as well as ongoing plans to monitor and support recommendations. The subcommittee lead will likely provide a verbal progress report during OFR case review meetings.

3. Tracking the status of a recommendation

Documenting the implementation status of a recommendation is encouraged. The OFR coordinator, in partnership with the subcommittee monitor role, is responsible for systematically monitoring the status of recommendations. If the OFR coordinator is not involved throughout the recommendation implementation process, he or she will need to follow up with partners (for example, the subcommittee lead or monitor) to learn the status of the recommendation. The OFR coordinator will work with the OFR data manager to ensure the status of the recommendation is tracked in the OFR database. Recommendation data elements are included in the OFR database discussed in Module 4E. Data Collection System.

Appendices



Appendix A

Resources for Model 1. Recruit Your OFR Members

Sample: OFR Recruiting Letter

[Insert agency letterhead]

[date]

[Name]

[Address]

[City, state, ZIP code]

Dear Colleague/Partner:

You are invited to participate in overdose fatality review (OFR), an innovative data-sharing process to address drug-related overdoses in our community.

OFR involves a case review process that generates information about decedents and their interactions with our services and systems. This information will be used to craft recommendations to prevent future similar deaths. This process has been effective for reviewing homicides, child fatalities, and maternal deaths and is now a nationally recognized model.

The OFR team will meet [monthly, quarterly] at the [location] from [time]. Members must commit to regular attendance, providing data about the decedent, and contributing to the discussion.

The authority to conduct case review through data sharing is detailed [information here] in [statute, MOU, regulations]. Attached is an interagency agreement and a confidentiality agreement that need to be signed prior to your participation on the OFR team.

Thank you for your consideration. Please direct any questions about the program to me. I look forward to working with you.

Sincerely,

[your name here]

Sample List: Facilitator Qualities

The facilitator of a fatality review team holds a special position. Preferred qualities that contribute to effective management of the team include the following:

- Good, active listener
- Communicates clearly
- Encourages open conversation
- Connects with the group and is trusted by partners
- Reads group's body language and dynamics
- Creates an inclusive environment: brings partners together, encourages sharing of information and views, and creates a safe place to share
- Sees all members as providing equal value
- Balances conversation to encourage less-vocal members to participate
- Navigates difficult conversations
- Professional
- Summarizes, pauses, and checks with the group before making decisions

One tool that can be helpful to facilitators is the APPLE technique:

Ask the question

Pause for members to think

Pick a member to answer/respond if no one is volunteering

Listen to the response

Expound or elaborate on what was said and relate it to the rest of the discussion

Sample Checklist: OFR Launch

- ☐ Identify the governance committee and the administrative lead agency
- ☐ Identify who will be responsible for the coordinator, facilitator, and data manager roles
- ☐ Establish interagency data sharing and confidentiality agreements
- ☐ Recruit case review team members
- ☐ Ask member agencies and members to sign an interagency data sharing agreement and confidentiality agreements
- ☐ Set OFR ground rules and expectations
- ☐ Review data and determine case selection criteria
- ☐ Develop protocols for secure data access
- ☐ Provide team member training
- ☐ Set the meeting schedule

Appendix B

Resources for Model 2. Plan Your OFR Meeting

Coordinator's Meeting Preparation Checklist

- ☐ Cases selected
- ☐ Guest members recruited
- ☐ Case information requested
- ☐ Meeting reminder email sent to members
- ☐ Case information summarized
- ☐ Activities since last meeting documented for sharing at meeting
- ☐ Agendas and other meeting materials printed

Sample: OFR Agenda

OFR Meeting Agenda

Date, Time,

Location

1. Opening Remarks and Introduction
    a. Members' introduction
    b. Updates from previous meeting
    c. Upcoming events
    d. Data presentation
    e. Review case selection criteria
    f. Other announcements
2. Goals and Ground Rules
    a. Read goals and ground rules
    b. Ask for any additional ground rules
3. Confidentiality
    a. Read confidentiality statement
    b. Collect signed forms
4. Case Presentation
5. Member Report-Outs (reverse chronological)
6. Group Discussion
7. Case and Timeline Summarized
8. Formulate Recommendations
9. Summarize and Adjourn
    a. Members reflect on how the meeting went
    b. Collect any paperwork with confidential information
    c. Remind members of confidentiality
    d. Encourage members to take time for self-care

Next meeting: date, time, and location

Sample: OFR Case Email

[Insert agency letterhead]

[date]

Dear Colleague/Partner,

You are invited to participate in the next OFR meeting on [date and time] at the [location].

The authority to conduct case review through data sharing is detailed [information here] in [statute, MOU, regulations]. Attached are the interagency agreement your agency has signed and a copy of the confidentiality agreement that must be signed and collected at the beginning of the meeting. Copies will be made available for your signature at the meeting.

We will be reviewing the following case(s) at the review. Keep this and all information you prepare about the case confidential.

Case 1.

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

Case 2.

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

Please be prepared to share any information you have about the individual, the community, and your services as it relates to the overdose death. See the attached guide to collecting case information and agency-specific data elements to summarize the information.

If you need additional information about the decedent for identification in your records, feel free to contact me at [phone number].

Sincerely,

[your name here]

Sample: Member's Guide to Collecting Case Information

Guiding questions for collecting information about the case:

- What was the nature and timing of your agency's contact with the decedent in the overdose death?
- What interactions did your organization or agency have with the decedent, and when?
  - What services, if any, was the decedent accessing around the time of his or her death?
  - What services, if any, were provided to the decedent's family members? What can we learn about the decedent's life through the agency's interaction with the family?
  - Did the decedent transition between service providers? Did any gaps in service occur, or were any service needs unmet? What were the reasons for those gaps? Were referrals made? What communication occurred among providers?
  - What were some missed opportunities in intervening or providing services?
  - What were the anticipated benefits of those services?
  - How did the decedent/family/neighborhood respond to services?
  - Was an intervention completed or in progress at the time of the death?
  - What were the outcomes of the interaction(s)?
- What were the strengths or protective factors of the decedent, the decedent's family/social network, or environmental context at the time of your agency's interaction?
  - Neighborhood, support system, social network, family, peer support, access to services, employment history, housing history, health insurance, environmental safety, education
- What were the risk factors of the decedent, the decedent's family/social network, or environmental context at the time of your agency's interaction?
  - Neighborhood, environment, exposure to violence, trauma or abuse, discrimination, injustice, criminal activity, loss of employment, abandonment, acute or chronic illness, injury, disability, transience
- What services or programs were being offered in the area during the incident? Were they available to the decedent?
- What public policies (such as criminal justice, health, economic, and social welfare) were most likely impacting the individuals and neighborhoods involved in the overdose death at the time of the incident?

Sample: Agency-Specific Data Elements

- Medical examiner/coroner
  - Autopsy results
  - Death scene investigation
  - Toxicology report
- Law enforcement (decedent and/or suspect)
  - Drug involvement
  - Gang, group, crew involvement
  - Criminal history
  - Treatment history
  - Location of incident
- Department of corrections (DOC)
  - Current DOC status
  - History of supervision
  - Drug and gang involvement
  - Treatment history
  - Mental health history
  - Medications
- Treatment providers
  - Treatment history—substance use and/or mental health
  - Medications
  - Trauma

Sample: OFR Two-Week Reminder Email

[Insert agency letterhead]

[date]

Dear Colleague/Partner,

Reminder: You are invited to participate in the next OFR meeting on [date and time] at the [location]. See attached agenda, and list of invited meeting members.

The authority to conduct case review through data sharing is detailed [information here] in [statute, MOU, regulations]. Attached are the interagency agreement your agency has signed and a copy of the confidentiality agreement that must be signed and collected at the beginning of the meeting. Copies will be made available for your signature at the meeting.

We will be reviewing the following case(s) at the review. Keep this and all information you prepare about the case confidential.

Case 1.

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time

Case 2.

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date and time,

Please be prepared to share any information you have about the individual, the community, and your services as it relates to the overdose death. See the attached guide to collecting case information and agency-specific data elements to summarize the information.

If you need additional information about the decedent for identification in your records, feel free to contact me at [phone number].

Sincerely,

[your name here]

Sample: Case Summary Outline

Presentation/Handout of Case Summary

- Name, aliases
- Date of birth, date of death
- Demographics (age, race, sex)
- Address of residence
- Incident location, date, and time
- Obituary summary information
- Pertinent news coverage information
- Relevant social media posts
- Details from interviews with the decedent's family members and social contacts

Sample: Summary Data Report

Summary data:

Medical examiner's/coroner's office: Year to date, we had [number] overdoses, [number] of which met our case selection criteria. Since our last review, there have been [number] overdose deaths. Compared to the same time last year, the cases are [compare number, substances, demographics].

EMS data: Year to date they responded to [number] overdoses, and since our last review, they responded to [number] overdoses. Compared to the same time last year, the cases are [compare number, substances, demographics].

Sample: Meeting Ground Rules

- Be on time—at the beginning of the meeting and coming back from breaks.
- Raise your hand if you have something to say. Only one person speaks at a time.
- Listen actively to what other people are saying.
- Be respectful—no mocking or attacking other people's ideas.
- See all members as equal. Avoid favoring members with leadership titles.
- Maintain and protect confidentiality.
- Use appropriate and sensitive language when discussing the case.
- Use person-first language, such as "a person addicted to drugs" versus "a drug addict."
- Avoid judging the decedent's decisions. Try to understand the decedent's experience through his or her eyes.
- Consider all factors that contributed to the decedent's substance use and overdose.

Appendix C

Resources for Model 3. Facilitate Your OFR Meeting

Sample Template: Meeting Minutes

OFR Meeting

Date:

Present: [Name, Agency]

Updates:

Incident#:

Date: Time: Address: District:

Case narrative:

Partner/agency reports (add/remove partners listed as appropriate):

- Medical examiner's/coroner's office:
- Emergency medical services:
- Police department:
- Department of corrections:
- Health department:
- Drug treatment provider(s):
- Hospital:

Themes:

Recommendations:

Sample: Governing Committee Report Outline

- General statistics report-out
  - Year-to-date, number of deaths
  - Since last meeting, number of deaths
  - Prior year same time frame, number of deaths
  - (Any other aggregate data available)
- Activities since last meeting
- OFR review team meeting schedule and attendance
- Number and types of cases reviewed
- Any planned new work
  - Recommendations
  - Recruiting new members
  - Case selection criteria change

Appendix D

Resources for Model 4. Collect Your OFR Data

Sample: Interagency Data Sharing Agreement

Interagency Data Sharing Agreement

This cooperative agreement is made on this _____day of _____ among the following agencies:

Office of the Medical Examiner/Coroner

County Child Protective Services

Office of the Prosecuting Attorney

Sheriff's Department

Police Department

County Health Department

(Others as Needed)

WHEREAS, the parties are vested with the authority to promote and protect the public health and safety and to provide services which will improve the well-being of children and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of a multiagency, multiprofessional overdose fatality review team, and the outcomes of the reviews will be the identification of preventable overdose deaths and recommendations for interventions and prevention strategies.

WHEREAS, the objectives of an overdose fatality review team are agreed to be:

Accurate identification and uniform reporting of the cause, manner, and relevant circumstances of every overdose death with special emphasis on those features that relate to potential preventability.

Improved communication and coordination of agency responses to overdose deaths in the investigation and delivery of services.

Design and implementation of cooperative, standardized guidelines for the investigation of certain categories of overdose death.

Identification of needed changes in legislation, policy and practices, and expanded efforts to prevent overdose deaths.

WHEREAS, the parties agree that all members signing this agreement are essential to an effective review.

WHEREAS, the parties agree that the review process requires case-specific sharing of records, and that confidentiality is inherent in many of the involved reports so that there will be clear measures taken to protect confidentiality, and no case review will occur without all present abiding by the confidentiality agreement.

NOW THEREFORE, it is agreed that all team members and others present at a review will sign a confidentiality agreement which prohibits any unauthorized dissemination of information beyond the purpose of the review process. The review team will not create any files with case-specific identifying data. Case identification will be utilized only to enlist interagency cooperation in the investigation, delivery of services, and development of prevention initiatives. It is further understood that there may be an individual case which requires that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on the agency's clear connection with the issue at hand. It is further understood that a participating agency may use information obtained at the review in accordance with the mandated responsibilities of that agency. It is also understood that team review data may be entered into [OFR database], where it will be maintained for the purpose of establishing a state central registry for overdose death data. This data will not include case-specific names. The registry will include standardized data from overdose fatality review teams throughout [state].

Sample: Confidentiality Agreement

Confidentiality Statement

The purpose of the overdose fatality review (OFR) team is to conduct a thorough review of preventable overdose deaths in [county] to better understand how and why an individual dies as a result of an overdose and to act to prevent other deaths.

To ensure a coordinated response that fully addresses all systemic concerns surrounding overdose deaths, all relevant data should be shared and reviewed by the team, as permitted by law, including historical information concerning the decedent, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure by law.

[State statutes] allow for overdose fatality reviews to remain confidential and can be exempt from the open meeting law. In no case will any team member disclose any information regarding team discussion outside of the meeting other than pursuant to the mandated agency responsibilities of that individual. Failure to observe this procedure may violate various confidentiality statutes that contain penalty. Public statements about the general purpose of the overdose fatality review process may be made, as long as they are not identified with any specific case.

The undersigned agrees to abide by the terms of this confidentiality policy.

Name:

Agency:

Signature:

Date:

Sample: Confidentiality Agreement and Review Sign-In Sheet

OFR Confidentiality Agreement

The purpose of the overdose fatality review team (OFR) is to conduct a thorough review of all preventable overdose deaths in [county] in order to better understand the circumstances of overdose deaths and how to act to prevent future similar deaths.

To ensure a coordinated response that fully addresses all systemic concerns surrounding overdose deaths, all relevant data should be shared and reviewed by the team, as permitted by law, including historical information concerning the decedent, his or her family, and the circumstances surrounding the death. Much of this information is protected from public disclosure by law.

[state statutes] allow for overdose fatality reviews to remain confidential and can be exempt from the open meeting law. In no case will any team member disclose any information regarding team discussion outside of the meeting other than pursuant to the mandated agency responsibilities of that individual. Failure to observe this procedure may violate various confidentiality statutes that contain penalty. Public statements about the general purpose of the overdose fatality review process may be made, as long as they are not identified with any specific case.

Dated [date] the undersigned agree to abide by the terms of this confidentiality policy.

Name	Agency

Template: OFR Data Sharing Protocol

1. Data Storage

   Upon receipt of the OFR data from OFR team members, how will the data be stored and for what period of time?

2. Data Transfer

   What information will be transferred to team members and in what format (email, letter, etc.)?

3. Data Security

   How will confidential information be protected during transfer to team members?

4. Data Sharing

   How will team members share information? If sharing prior to the review, how will information and records be transferred to the team coordinator and how will they be protected? If sharing at the reviewing, what format will the data be in and will it be kept by the team coordinator after the meeting?

Appendix E

Resources for Model 5. Build a Recommendation Plan

Sample: Recommendation Work Plan

Recommendation	Activity/Action Steps	Lead Agencies/ Supporting Agencies	Timeline

For more information about Overdose Fatality Reviews, visit

www.cossapresources.org

Appendix V

Resources for Creating a Drug Fatality Review Committee

1. National Center for State Courts
    - https://www.ncsc.org/ne-rjoi/ofr-team

2. National Library of Medicine
    - https://pmc.ncbi.nlm.nih.gov/articles/PMC9531981/