Attachment 8. Nevada State Opioid Response Needs Assessment

Scope of the Problem

Nevada is composed of 17 counties. Three of the counties are considered urban, three rural, and 11 frontier. Ninety-one percent (91%) of Nevada's population lives in the three urban counties, which accounts for 13% of Nevada's land. The remaining 9% of the population lives in the rural and frontier counties which cover 87% of the State. The spread of the population presents challenges in access to care. Eleven (11) of the 17 counties in Nevada are designated as health professional shortage areas.[1]

Prescribing. Nevada ranked nineteenth for opioid painkiller prescribing rate in 2020, down from twelfth in 2017. The national opioid prescribing rate was 43.3 per 100 people, lower than Nevada's, at 47.4.[2] According to the CDC, 6 of the 17 counties have prescribing rates higher than the national rate and 4 of 17 are at or above the State's rate.[3]

Adverse Child Experiences (ACES). The prevalence of past 30-day use of a pain medicine without a prescription and lifetime use of a pain medicine without a prescription, heroin, cocaine, and methamphetamine was higher among youth who experienced ACEs compared to those who had not.[4] LGBT students reported a higher incidence of multiple ACEs. [5]

Misuse. Estimates of past year use of opiates were higher among Nevada youth and adults, compared to the overall U.S. rates. Stimulant use was higher in Nevada only among those aged 18 and over.[6] Past 30-day use of stimulants, opioids, and injection drug use was higher among LGBT youth.[5]

Self-reported prenatal opioid and stimulant use has remained fairly steady at approximately 130 substance-exposed live births per year. Neonatal abstinence syndrome (NAS) admissions peaked in Nevada in 2016. From 2016 to 2020, inpatient admissions for NAS decreased 42%, from 9.2 per 1,000 live hospital births to 5.7, then increased 14% in 2021 to 6.6.[7]

Hospitalizations. The rate of opioid-related emergency department (ED) visits has increased through 2021 (see Table 1).[8] Inpatient hospitalization rates increased through 2018 and have decreased slightly each year since.[9] The opioid-related ED encounters and inpatient admissions rate is highest among White individuals, followed by Black, then American Indian/Alaska Native.[10] The rate of stimulant-related ED visits increased from 2018 to 2019, remained steady in

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

[2] Centers for Disease Control and Prevention. U.S. State Opioid Dispensing Rate Maps, 2020. Retrieved from https://www.cdc.gov/drugoverdose/rxrate-maps/index.html

[3] Centers for Disease Control and Prevention. U.S. County Opioid Dispensing Rates, 2020. Retrieved from https://www.cdc.gov/drugoverdose/rxrate-maps/county2020.html

[4] 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 Nevada Middle School Youth Risk Behavior Survey (YRBS): Adverse Childhood Experiences (ACEs) Special Report.

[5] Anderson, M., 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): Sexual and Gender Identity Special Report.

[6] Substance Use 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)*, 2020.

[7] Benschoff, A. (2022). *Prenatal Substance and Marijuana/Cannabis Use, Neonatal Abstinence Syndrome, and Child Welfare Impacts.* Office of Analytics, Department of Health and Human Services, State of Nevada.

[8] Nevada Overdose Data to Action. (2022). Suspected Rates of Opioid- and Stimulant-Related Overdose Emergency Department Visits from Syndromic Surveillance in Nevada, 2018-2021.

[9] Nevada Department of Health and Human Services, Office of Analytics, Nevada Opioid Surveillance Dashboard, updated June 21, 2022.

[10] Nevada State Opioid Response. (2022). Nevada State Opioid Response Tribal Needs Assessment.

2020, then decreased slightly in 2021.[8] The inpatient admission rate for stimulants increased from 2011 to 2020 from 88.6 to 402.4 per 100,000. [11]

Table 1. ED Visits per 100,000 Opioids and Stimulants[6]

	2018	2019	2020	2021
Opioid-Related ED Visits	71.2	70.2	87.8	91.0
Stimulant-related ED Visits	18.9	22.9	23.0	21.8

Substance Use Disorder Treatment. Nevada completed a system-wide assessment using SAMHSA's Calculating an Adequate System Tool (CAST) in June 2019. The results are broken down into the five regions of the Regional Behavioral Health Policy Boards—Clark County Region, Northern Region, Rural Region, Southern Rural Region, and Washoe County Region. According to the CAST, all five regions did not have an adequate number of short-term (less than 30 days) or long-term (more than 30 days) residential treatment beds. Access to residential or withdrawal management treatment is limited in the rural and frontier counties, with 95% of residential treatment and inpatient withdrawal management beds located in Las Vegas, Reno, or Carson City, and most (85%) are not eligible for Medicaid reimbursement. No region had adequate access to OTPs or OBOTs.[12] In 2018, only 15% of pregnant women with an opioid use disorder covered under Medicaid received treatment.

Recovery Support Services. According to the CAST, of the five regions, only the Washoe region had access to enough employment support for those in treatment and housing assistance. Transportation for those in treatment was lacking for the Rural Region and the Clark County Region.[6] Forums and interviews held by the Nevada Minority Health and Equity Coalition suggest that individuals in rural areas have a lower knowledge of recovery resources, family members experience a greater deal of stress due to a lack of understanding about MAT and other treatment and recovery options.[13]

Overdose Deaths. The opioid-related death rate decreased from 2011 to 2014, remained fairly stable through 2019, then from 2019 to 2020 there was a 45% increase in opioid-related overdose deaths. From 2020 to 2021 there was just a slight increase of 3%.[14] The stimulant-related overdose death rate increased from 2011 to 2021.[15] In the first half of 2021, opioids were involved in 65% of overdose deaths. Of the opioid-related overdose deaths, 34% were due to illicitly manufactured fentanyl, 22% were due to prescription opioids, and 15% were due to heroin.[16] Over half of deaths (58%) involved stimulants. Fentanyl-related opioid overdose deaths increased 227% from 2019 to 2020.[17]

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[11] Nevada Department of Health and Human Services, Office of Analytics, Methamphetamine and Stimulant Dashboard, updated November 24, 2011.

[12] 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.

[13] 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.

[14] Office of Analytics. (2022). Opioid Related Deaths by County – 2016-2021. Office of Analytics, Department of Health and Human Services, State of Nevada.

[15] Office of Analytics. (2022). Stimulant Related Deaths by County – 2016-2021. Office of Analytics, Department of Health and Human Services, State of Nevada.

[16] Nevada Overdose to Action. *Nevada State Unintentional Drug Overdose Reporting System*: *Report of Deaths: January to June 2021 – Statewide*. https://nvopioidresponse.org/wp-content/uploads/2019/05/sudors_report_2021_p1_statewide.pdf

[17] Nevada Overdose to Action. *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

In Nevada, most (82%) opioid overdose deaths involve an additional one or more substances. From 2019 to 2020, there was a 68% increase in deaths from opioids and stimulants and a 41% increase in opioid and stimulant deaths involving fentanyl. Opioid and stimulant overdose deaths were highest among Black, non-Hispanics in 2020. Deaths involving opioids and stimulants increased 167% and deaths involving opioids and benzodiazepines increased 343% among the Hispanic population.

Overdose deaths involving opioids and stimulants and those involving opioids and benzodiazepines were both highest in Washoe County. The Clark region saw a 155% increase in opioid and benzodiazepine overdose death and the Southern Rural Region a 100% increase from 2019 to 2020.[18] For more than one-third (34%) of overdose deaths in 2020, the individual had a co-occurring mental health disorder.[16]

Strengths, Unmet Needs, and Critical Gaps

Strengths. There are several strengths in the way the opioid crisis has been addressed over the past several years.

Table 2. Strengths of Nevada's Service Systems

Strength	
Development of IOTRCs	Under Opioid-STR, Nevada established Integrated Opioid Treatment and Recovery Centers (IOTRCs) or "hubs" of a hub and spoke model.
Expansion of CCBHCs	Developed in partnership with the CCBHC 223 demonstration program, there are now 8 certified CCBHCs in Nevada to reduce barriers when seeking services.
Prioritization of Peer Support Services	Peers have been prioritized in the treatment of pregnant women by their inclusion in the Perinatal Health Action Plan and in "Nevada's Sustainability Plan to Support Expansion of SUD and OUD Treatment and Recovery Provider Capacity."
Application for an 1115 demonstration waiver	Nevada submitted an 1115 waiver to CMS for the addition of residential and withdrawal management services for Medicaid payment for individuals 22 to 64 years old and the addition of case management for these individuals. If approved, the waiver will be effective January 1, 2023.[19]
Prioritization of Pregnant Women	Nevada has expanded reimbursement for SBIRT, developed new guides in partnership with ASTHO OMNI, and provided training on implementation of screening practices in health care centers throughout the state.
Use of the Project ECHO Model	Medical providers throughout the state have access to specialized training and consultation on pain management and medication assisted treatment through utilization of Project ECHO.

Gaps. The *Nevada Resilience Fund: Opioid Needs Assessment* identified a comprehensive list of gaps. Table 3 is an abridged list of gaps that SOR III has the potential to target.

Table 3. Gaps in Nevada's Service Systems

Prevention Gaps	• Partial implementation of the Zero Suicide initiative • School-based prevention programs • Education for school systems, parents, and law enforcement

[18] Nevada Overdose to Action. *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

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

	• Education on treatment options, especially for those without housing • Lack of 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 • Stigma reported by people with lived experience through difficulty obtaining and keeping housing and employment and anxiety over seeking help, especially among veterans and tribal members
Harm Reduction Gaps	• Education on harm reduction resources and methods, including Naloxone use • Harm reduction in rural areas without other community members knowing about the individual's use
Treatment Gaps	General Treatment Gaps **Treatment availability was the most significant and immediate need, as well as:** • Insufficient treatment in rural areas • Nevada Medicaid and overdose data suggest disparities in populations between those in treatment versus fatal overdose rates • Peer support throughout treatment • Community-based accessible resources after release from the justice system • Treatment access for pregnant women • Drug courts, other treatment, and housing services are not available Statewide • Screening, identification, and referral to treatment Outpatient Treatment Gaps • OBOT in certain areas • MAT in rural areas and on reservations • MAT and other treatment interventions in justice facilities is lacking in many areas • Limited availability of evidence-based treatment for those using multiple substances and for those with co-occurring mental health and physical health disorders • Formal collaborative care for individuals at risk for suicide Withdrawal Management, Inpatient, and Residential Gaps • Withdrawal Management and Residential Services are not be eligible for Medicaid services for ages 18 years–64 years without the proposed 1115 SUD Demonstration waiver Crisis System Gaps • Mobile crisis, especially outside of central Las Vegas • Follow-up after crisis to ensure stability and address barriers to care Limited or Lacking Treatment Data • Health outcomes for those in SUD services • Lack of detailed breakdowns by race/ethnicity, housing status, veteran/military status, pregnant women, LGBTQ+ status, immigration status Provider Gaps • Education of patients by prescribers on pain management expectations and the risks of opioids • Utilization of/referral to other pain management options
Recovery Support Gaps	• Funding/insurance for long-term care for recovery and residential programs • Programs for the individuals released from the justice system • Parenting education • Recovery centers • Housing vouchers and affordable housing • Employment for those receiving treatment and in recovery

	• Volunteer and vocational opportunities

Number and Location of OTPs and OBOTs

12 counties have DATA-waivered providers: Carson City, Churchill, Clark, Douglas, Elko, Lincoln, Lyon, Mineral, Nye, Pershing, Washoe, and White Pine. The number of OBOTs increased from 2017-2020, but has decreased slightly since the COVID-19 pandemic. When last assessed in 2017, most OBOTs were not prescribing to their waiver capacity.

There are 15 Opioid Treatment Programs (OTPs) in Nevada across Clark County, Washoe County, and Carson City (see Table 4). One medication unit provides methadone in Lyon County. None of the OTPs receive funding from the Substance Abuse Block Grant.

Table 4. Nevada Opioid Treatment Programs and Location

Program	County
Adelson Clinic	Clark
Behavioral Health Group	
• Behavioral Health Group – Cheyenne	Clark
• Behavioral Health Group – Desert Inn	Clark
• Behavioral Health Group – McDaniel	Clark
• Behavioral Health Group – Reno	Washoe
Desert Treatment Clinic	Clark
Mission Treatment Centers	
• Mission Treatment Centers – Henderson	Clark
• Mission Treatment Centers – Las Vegas	Clark
New Beginnings Counseling Center Eastern	Clark
Life Change Center	
• Life Change Center – Carson City	Carson
• Life Change Center – Reno	Washoe
• Life Change Center – Sparks	Washoe
Seven Hills Hospital, Inc.	Clark
Vegas Treatment Center	Clark
Washoe County Detention Center	Washoe

Other Opioid and Stimulant Funding Activities

All other funding to address the opioid crisis is outlined in Table 5.

Table 5. Nevada Funding to Address the Opioid Crisis

Funding Stream	Strategies/Activities	Funding Period
CDC Overdose to Action (OD2A) – State of Nevada	• Implementation of OpenBeds to link individuals to care • Substance misuse specialists in each behavioral health region to link individuals to care • Support the PDMP and analysis of prescription and co-prescription data • Set up fusion center in Northern Nevada • Prepare reports on trends opioid prescriptions, opioid-related hospitalizations, and opioid-related deaths by state and region, polysubstance use, circumstances of the overdose, and characteristics of the decedents • Implementation of a media campaign • Implementation of SMART Recovery	9/19-8/23

	• Evaluation and enhancement of mental health services in jail • Purchase and use of a mass spectrometer for drug testing and surveillance activities • Pilot the use of NaloxBoxes • Software to enhance hospital overdose reporting • Support of opioid and stimulant related questions in the YRBS	
Overdose to Action – Southern Nevada Health District	• Track the extent to which individuals who utilize SSP are linked to treatment or risk reduction services • Track linkage to care outcomes among pregnant women who use substances enrolled in a local community program • Utilize a harm reduction/overdose response team to link individuals to MAT, harm reduction supplies or services, treatment for HIV or Hep C, social services, housing assistance, and peer support • Train providers on SBIRT and implementation • Track drug use and overdose history among individuals using opioids and injecting drugs • Track drug supply by testing drug products and paraphernalia • Link EMS data and syndromic surveillance data • Produce regular surveillance reports including law enforcement and first responder data	9/19-8/23
ODMAP Demonstration Grant	• State EMS was awarded funding to facilitate the implementation of the API from the state EMS database to ODMAP • Continued with the development and implementation of the Community Overdose Spike Response Plans which included outreach, prevention, harm reduction activities, and exercising of the Community Overdose Spike Response Plans for nine sites	3/1-2/23
SAMHSA Strategic Framework Partnership for Success (PFS)	• Reduce the nonmedical use of prescription drugs among and the consequences that result from such use, with a focus on persons ages 9-20 • Implement a comprehensive prevention strategy through community education, social marketing/media, physician training, and drop boxes/Take Back events through 13 funded coalitions	9/18-9/23
SABG Block Grant: Funding Opportunity 003	• Target efforts to encourage the use of Prescription Drug Monitoring System by prescribers • Provide education on the use of naloxone and education on the Good Samaritan Law	10/21-9/23
COSSAP	• Implement or supplement MOST or FAST programs at six subaward sites covering seven counties	10/22-
MERIT	• Evaluate the implementation of hospital-based overdose response	

Opioid Antagonist Medication Saturation Plan

The state has determined the need to expand the definition beyond naloxone to include opioid antagonist in order to include upcoming reversal medication currently in the process of obtaining FDA approval that is not naloxone based but targeted for fentanyl intervention.
Saturation rates: Nevada has set the goal of an opioid antagonist present at 80% of witnessed overdoses. This was based upon the model developed by Irvine et. al. (2022). The Irvine model was based upon old data that did not account for the shift from prescription misuse to fentanyl contamination in the illicit drug supply, changing the needed approach for distribution. During the timeframe July 1, 2021 to June 30, 2022, Nevada reported 420 fatal overdoses with a

bystander present. To ensure the probability of having an opioid antagonist present at approximately 80% of witnessed overdoses, the state would need to distribute 115,000 kits annually. Over the noted period of time, 27,916 kits have been distributed into the community. There would need to be an increase of 87,084 kits annually. Nevada does not have the fiscal resources or infrastructure to support this goal. Over the next 2 years, Nevada will work on infrastructure development to support a distribution of 50,000 kits annually.

Targeted distribution and communication strategy: Partnering with OD2A to analyze the data from SUDORS and Vital Death Records, several locations have been identified as overdose hotspots. To best address greater need in these areas, several actions are being taken to increase the influx of opioid antagonist medication availability:

- Improve relationships with industry, focusing on entertainment to expand more targeted distribution sites related to risky behavior such as casinos, sporting organizations, cannabis dispensaries, bars and clubs, and the sex industry.
- Expand jail-based distribution and relationships with criminal justice agencies outside of the metropolitan areas
- Initiate emergency room opioid antagonist distribution, possibly in partnership with ED Bridge and Zero Suicide
- Increase availability of Harm Reduction Vending Machines into hotspot locations
- Work with the Attorney General's Office to reduce barriers to access through state legislation

Since the beginning of 2020, the state has seen a 200% increase in opioid-related overdoses among Latinx/Latine populations. This is in addition to the consistently higher rates among other BIPOC populations including members of tribal populations. In order to address the shortfall of opioid antagonist medication available among this population, several programs will be initiated or expanded upon for greater impact:

- Increased production and distribution of culturally appropriate translated materials and direct outreach including trainings given in alternative languages.
- Continued partnership with OD2A to utilize focus group outcomes to tailor approaches.
- Expand partnerships with community organizations that are well connected with BIPOC communities including: human trafficking response programs, vaccination systems, crisis centers.
- Recruit Faith-Based Organizations to expand access to opioid antagonist resources and reduce harm reduction barriers related to stigma
- Engage with the Minority Health Equity Coalition to acquire guidance to identify partners to reach populations that are traditionally more resistant to outreach efforts
- Expand partnerships with peer mutual aid groups and statewide prevention coalitions. These programs are often able to engage directly with specific community networks working with underserved populations.
- Develop relationships and establish distribution through labor associations such as builder associations, culinary associations, and targeted outreach to day laborers.
- Increased partnerships with Nevada's Tribal Consultation groups to improve relationships and establish distribution sites

- Partner with recipients of Tribal SOR to work alongside and assist with overdose education

Partnerships: Several partnerships exist and can be leveraged to support expansion of distribution efforts. These partnerships include:

- Attorney General's Office
- Fund for a Resilient Nevada (aka. Opioid Litigation Funding)
- Minority Health Equity Coalition
- Nevada Medicaid
- Nevada Prevention Coalitions
- Nevada Tribal Consultation
- Nevada OD2A surveillance and assistance targeting at risk locations and populations
- ODMAP
- Recovery Friendly Workplace Initiative
- Southern Nevada Health District, CARA funds

Budget:

Year 1: 40,000* units x $68.00 = $2,720,000

Year 2: 55,000* units x $68.00 = $3,740,000

*This will include first responder distribution

Detailed timeline:

Year 1 (in Quarters)					Year 2			
Goal/Activity to be completed by project staff & partners	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Goal 1: Increase the number of distribution locations serving high risk populations								
Activity 1: Increase the number of criminal justice/first responder distribution location by 1 quarterly	x	x	x	x	x	x	x	x
Activity 2: Increase 2 distribution sites serving the entertainment industry per quarterly	x	x	x	x	x	x	x	x
Activity 3: Increase the number of 1 medical setting/emergency department distribution location by 1 every 6 months		x		x		x		x
Activity 4: Increase the number of harm reduction vending machines by 4 annually				x				x
Goal 2: Improve outreach and distribution to BIOPC populations								
Activity 1: Produce culturally appropriate translated materials	x							
Activity 2: Increase number of Mutual Aid and Coalition distribution locations by 1 per quarter	x	x	x	x	x	x	x	x
Activity 3: Increase Faith Based participation in distribution by 1 every 6 months		x		x		x		x
Activity 4: Distribute through a labor association by 1 every 6 months	x		x		x		x	
Goal 3: State litigation to reduce barriers to access naloxone								
Activity 1: Support Attorney General's office with needed data, networking, and technical assistance					x	x		

Procurement will occur upon Nevada IFC approval with an approximate start in December 2022.